

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06798

06780

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IT <u>9 hrs. 35 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laburnum</u>		e. STREET ADDRESS <u>201 Fredrick Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Susie Adams</u>		4. DATE OF DEATH <u>May 23 1967</u>	
SEX <u>F</u>	5. COLOR OR RACE <u>W</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <u>12/25/1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Susan Strother</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Marilyn Claggett Lane Rockville MD</u>	
17. INFORMANT <u>Marilyn Claggett Lane Rockville MD</u>		Address <u>612 W. Harmon</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myxema, right</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>lost</u> (b) <u>lost</u> (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Ball</u> M.D.		22. DATE SIGNED <u>5/24/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN PARK.</u>	23d. LOCATION (City or town) (County) (State) <u>ROCKVILLE, MD</u>
24. FUNERAL DIRECTOR <u>Robert L. Saunders</u> ADDRESS <u>ROCKVILLE, MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Handwritten text, possibly a signature or address, appearing upside down.

John D. Bell

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08273

06793

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE - <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase -</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Irene Apartment Building</u>		e. STREET ADDRESS <u>4811 Grantham St.</u>	
3. NAME OF DECEASED (Type or print) <u>Paul C. Hebersold</u>		DATE OF DEATH <u>May 29 1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>T</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Hebersold</u>		14. MOTHER'S MAIDEN NAME <u>DORA Hoack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>408-44-9839</u>	
17. INFORMANT <u>Florence Hebersold</u>		Address <u>wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries. Severe</u> 978X DUE TO (b) <u>Fall from roof -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped from roof of 17 Story Apt. Bldg.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 PM May 29 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apt. Bldg.</u>		20f. (City or town) (County) (State) <u>Cherry Chase Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		22. DATE SIGNED <u>5/29/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland P.G. Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawlers Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave Wash.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 7 1967</u>			

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CERTIFICATE OF DEATH

06781

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS Route #5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Dean Last ALLEN		4. DATE OF DEATH Month May Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1919
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William John Bremsteller		14. MOTHER'S MAIDEN NAME Annie Laurie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-5848	
17. INFORMANT Maryland Address Sylvester J. Allen, Route #5, Salisbury		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis DUE TO (b) Widespread carcinomatosis due to primary carcinoma of the cervix DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from May 19, 1967 , to May 24, 1967 , that (b) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>R. M. Farmer</i>		22b. DATE SIGNED 24 May 1967	
22c. PHYSICIAN'S NAME (Type) R. M. Farmer, M. D.		22d. ADDRESS Naval Hospital, Bethesda,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Murphy Funeral Home		25a. REC'D BY REGISTRAR MAY 26 1967	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		25c. ADDRESS 3524 Columbia Pike, Arlington, Virginia	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06795

CERTIFICATE OF DEATH

06782

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2516 Jackson Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Jane Middle Francis Last ALLEN				4. DATE OF DEATH Month May Day 14 Year 67			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 8, 1967		9. AGE (In years lost birthday) yrs. 8	IF UNDER 1 YEAR Months 8 Days 6	IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin G. Allen				14. MOTHER'S MAIDEN NAME Dorothy Jean Downs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Vienna Address Virginia Benjamin G. Allen, 2516 Jackson Pewi			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar subarachnoid hemorrhage, brain 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 8, 1967 , to May 14, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 1225M , from causes and on the date stated above.							
22a. SIGNATURE <i>A. E. Tompkins</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> AM STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 16, 1967	
22c. PHYSICIAN'S NAME (Type) A. E. Tompkins, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL HOME Falls Church Funeral Home				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE <i>g. Charles Judge</i>	
24. ADDRESS 1102 West Broad St., Falls Church, Va.							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06796

CERTIFICATE OF DEATH

06783

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY in 1b 6 hrs. 35 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS Rt. 2, Box 209		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle MAN Last Alley Sr.				4. DATE OF DEATH Month 5 Day 16 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/13		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rihcard Alley				14. MOTHER'S MAIDEN NAME Ruth Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-28-7763		17. INFORMANT Address Hospital Records, Olney, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma ma, Lung 102X DUE TO (Proved biopsy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Months ??						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAR , 19 67 , to 5-16 , 19 67 , that (I) (we) last saw the deceased alive on 5/16 , 19 67 , and that death occurred at 8-4 M, from causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-17-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher				22d. ADDRESS 105 Russell Ave., Gaithersburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City or Town) (County) (State) Laytonsville Mont. Md.	
24. FUNERAL DIRECTOR Francis H. BARBER				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06797

CERTIFICATE OF DEATH

06784

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut or Residence before admision) a STATE <u>Tennessee</u> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>45 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp ta., give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d STREET ADDRESS <u>2701 Capers Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Anuradha Sharad Amtey</u>		4 DATE OF DEATH Month Day Year <u>May 15, 19 67</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u></u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>16 July 1943</u>
9 AGE (In years lost birthday) <u>23</u> yrs		10 FUND 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scanner</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State or foreign country) <u>Pakistan</u>		12 CITIZEN OF WHAT COUNTRY? <u>India</u>	
13 FATHER'S NAME <u>Benjamin Solomon</u>		14. MOTHER'S MAIDEN NAME <u>Shanta Talkar</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) <u>No</u>		16 SOC. A. SECURITY NO <u>Not available</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal bleeding</u> DUE TO <u>with multiple clotting defect</u> (b) <u>Progressive hepatic failure of unknown etiology/</u> DUE TO <u>7 months</u> (c) <u>Gram negative septicemia</u> DUE TO <u>12 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>March 31</u> , 19 <u>67</u> , to <u>May 15</u> , 19 <u>67</u> , that (b) (we) last saw the deceased alive on <u>May 15</u> , 19 <u>67</u> , and that death occurred at <u>5:40 P.M.</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Alexander R. Lawton</u> M.D.		22b DATE SIGNED <u>May 16, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Alexander R. Lawton, M.D.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a BURIAL (CREMATION, REMOVAL) (Specify)	23b DATE THEREOF <u>5-16-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u>	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>James 387 St. ...</u>		25a REC'D BY REGISTRAR <u>MAY 19 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER:

5 may be retained for your files

TO FUNERAL DIRECTOR:

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

5 may be retained for your files

TO FUNERAL DIRECTOR:

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

5 may be retained for your files

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death

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TO FUNERAL DIRECTOR:

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

5 may be retained for your files

TO FUNERAL DIRECTOR:

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

06798

06785

PLACE OF DEATH
a COUNTY

Montgomery
Bethesda

MARYLAND

LENGTH OF DAY

11 A

USUAL RESIDENCE Where born
a STATE

Maryland
Bethesda

b COUNTY

Montgomery

d NAME OF DECEASED

NAME OF DECEASED

LUDWIG John Henry Antmann

DATE OF DEATH

May 24 1967

SEX

male

6 COLOR OF RACE

White

MARRIAGE

☒ NEVER MARRIED

☐ WIDOWED

☐ DIVORCED

8 DATE OF BIRTH

Dec. 23/07

9 AGE

59

10 MONTHS

24

11 DAYS

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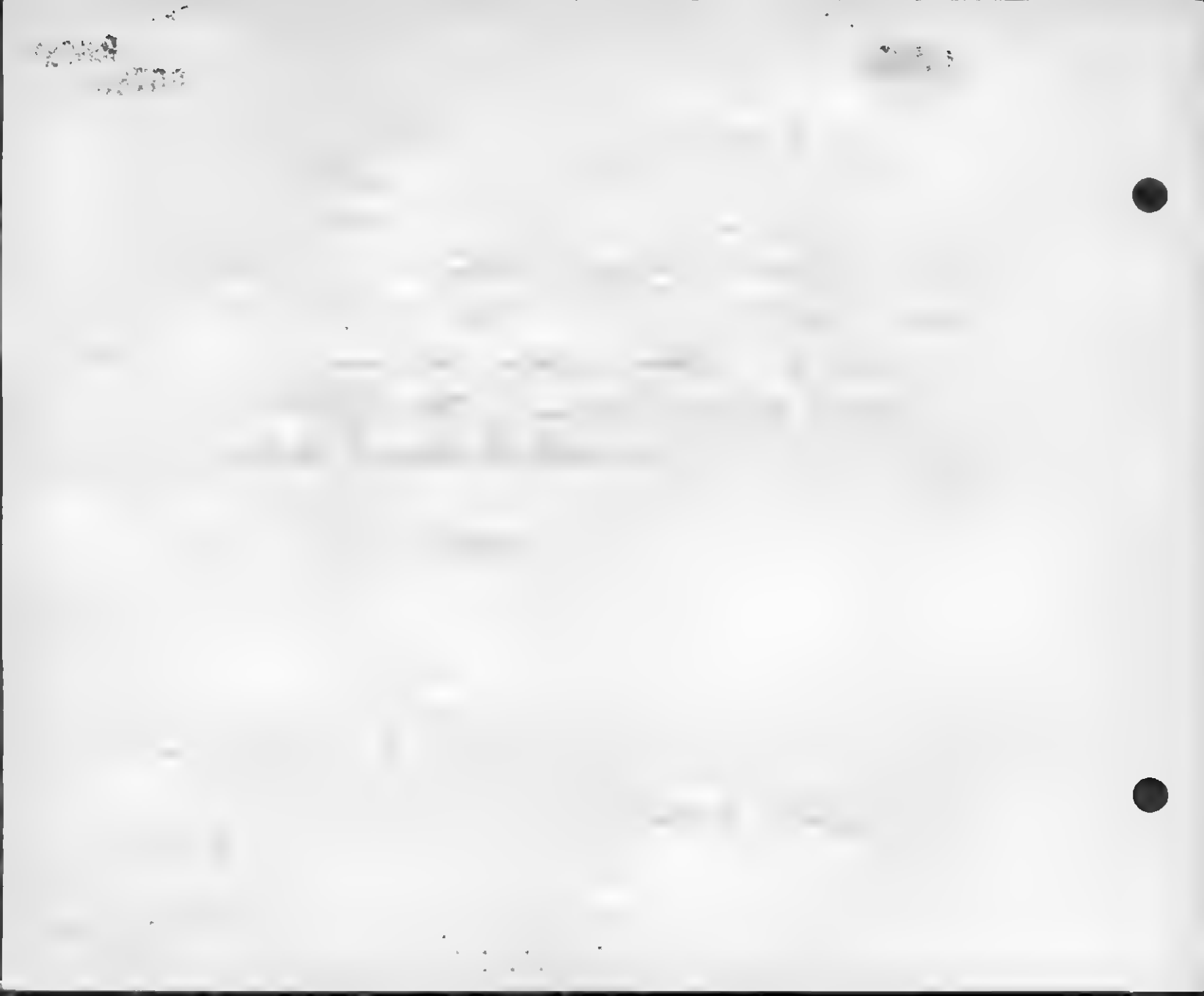
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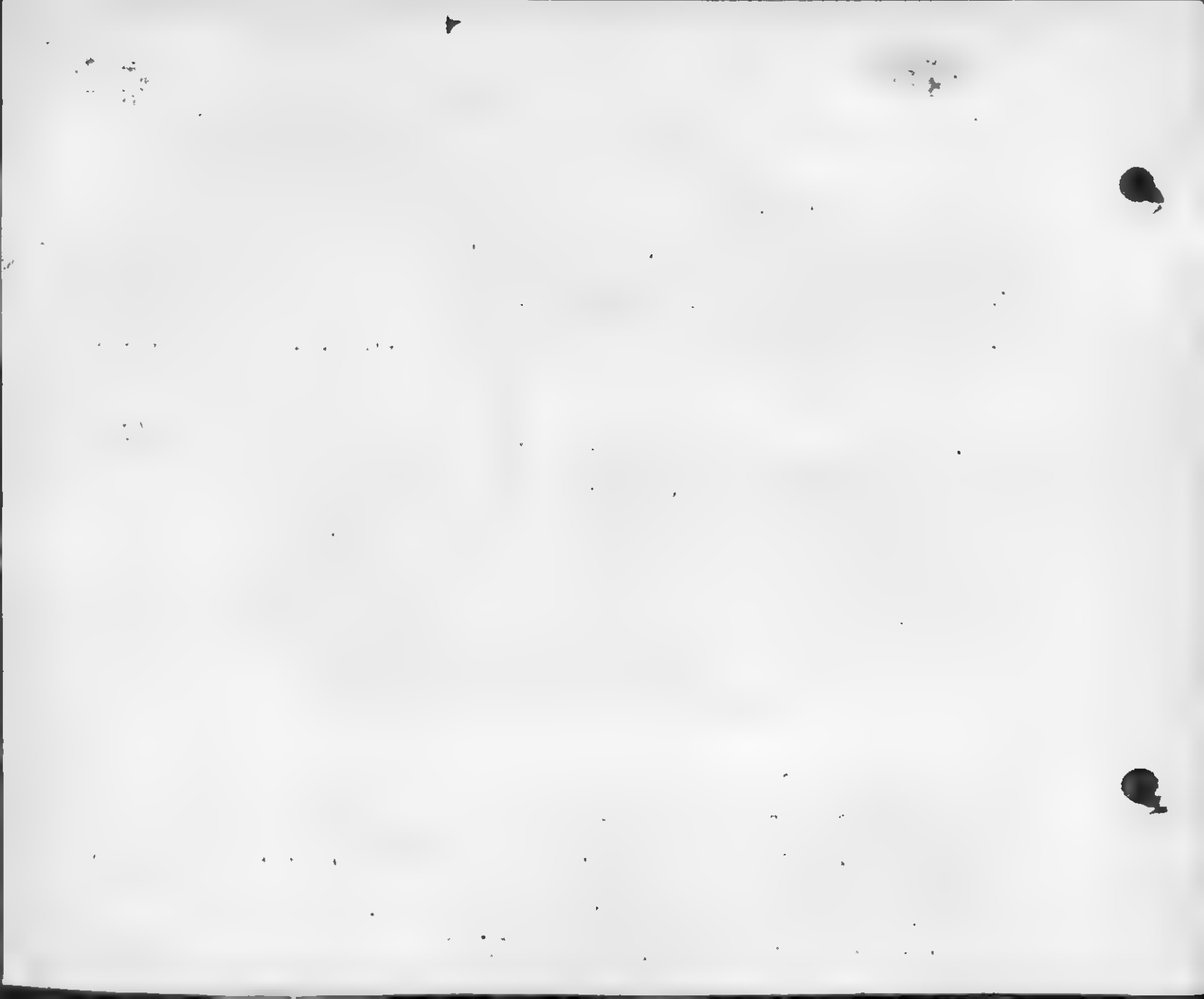
CERTIFICATE OF DEATH

Reg. Dist. No. **06786**

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5328 Goldsboro Road d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 5328 Goldsboro Road		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda d. STREET ADDRESS 5328 Goldsboro Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) SARAH C. ARMSTRONG First Middle Last 4. DATE OF DEATH Month May Day 25 Year 1967		5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH 10-27-1877 9. AGE (In years last birthday) 89 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Retired 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Finchan 14. MOTHER'S MAIDEN NAME Ann Mullinix		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO 213-54-9500 INFORMANT Mrs. Helen Thompson, See Item #2. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]. PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Chronic Atrial Fibrillation		INTERVAL BETWEEN ONSET AND DEATH 1+ yrs. 20+ yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 67 , to May , 19 67 , that I last saw the deceased alive on May 25 , 19 67 , and that death occurred at 7:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 915 19th Street, N.W. Washington, D.C. 5/25/67 ACTUAL SIGNATURE John F. Gustafson M.D. PHYSICIAN'S NAME (Type) Dr. John F. Gustafson 915 19th St, N.W. Washington, DC.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-1967	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.		24a. REC'D BY REGISTRAR Charles Judge 24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 29 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

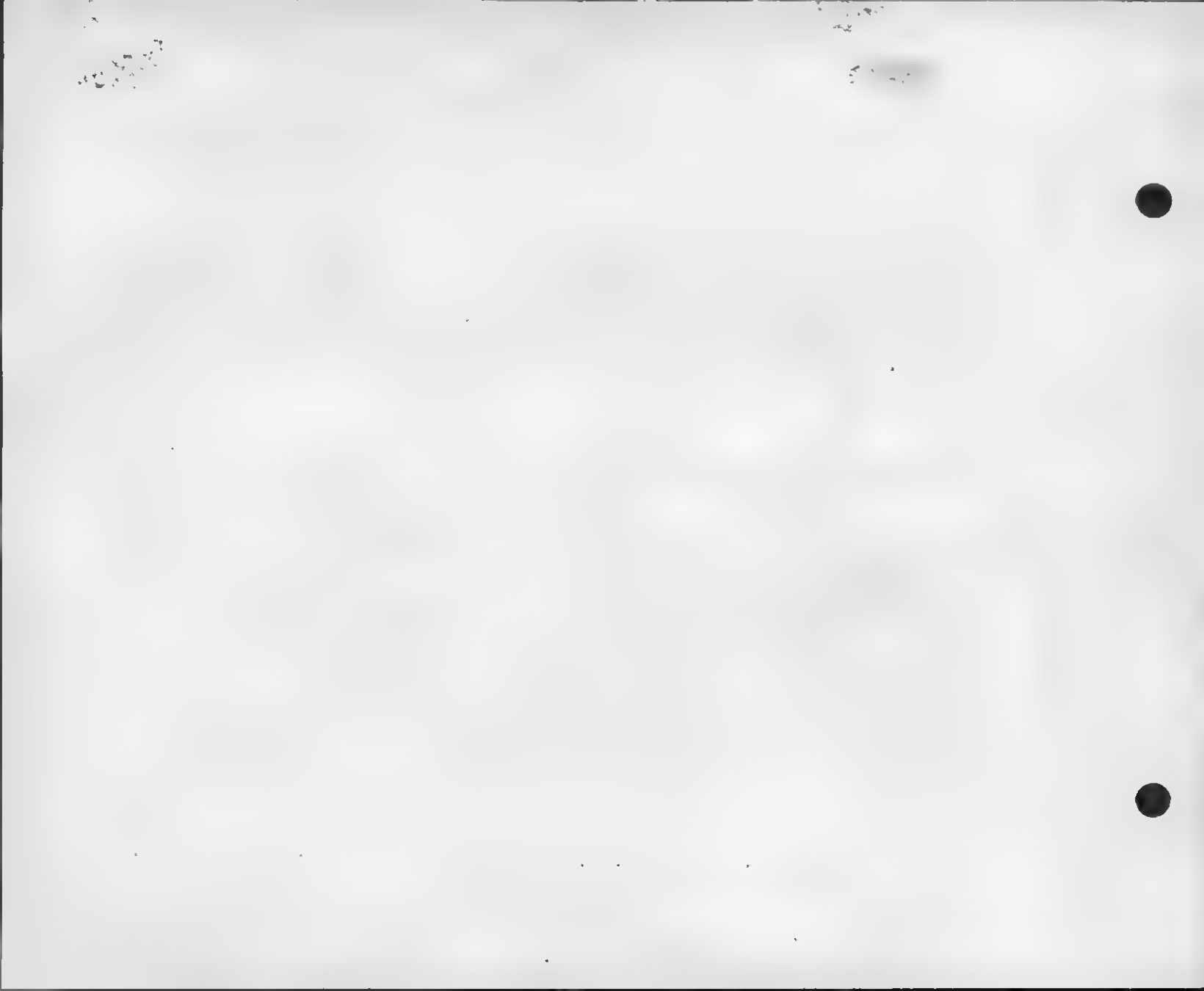
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

06800

CERTIFICATE OF DEATH

06787

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY N to 127 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntington		d. STREET ADDRESS Bayview Mobile Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type of print) First Major Middle McKinley Last ASHE		4 DATE OF DEATH Month May Day 30 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 28, 1930
9 AGE (In years last birthday) 36 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Wolf Mountain, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Luther Ashe		14 MOTHER'S MAIDEN NAME Nina Hall	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) Yes 1948-1967		16 SOCIAL SECURITY NO 238 42 1536	
17 INFORMATION ASHE		Address Maryland Mrs. Shirley Anne, Bayview Mobile Manor	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacterial endocarditis 4-11 DUE TO (b) Aortic valve replacement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Aortic insufficiency			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o m p m 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from Jan. 23 , 19 67 , to May 30 , 19 67 , that (he) (we) last saw the deceased alive on May 30 , 1967, and that death occurred at 105P M , from causes and on the date stated above.			
22a SIGNATURE Donald H. Gaylor - M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED June 1, 1967
22c PHYSICIAN'S NAME (Type) Donald H. GAYLOR, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL Burial	23b DATE THEREOF 6/2/1967	23c NAME OF CEMETERY OR CREMATORY Middle Fork Cemetery	23d LOCATION (City or Town) (County) (State) Rossmann, North Carolina
24 FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D. C.		25a REC'D BY REGISTRAR JUN 5 1967	25b REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

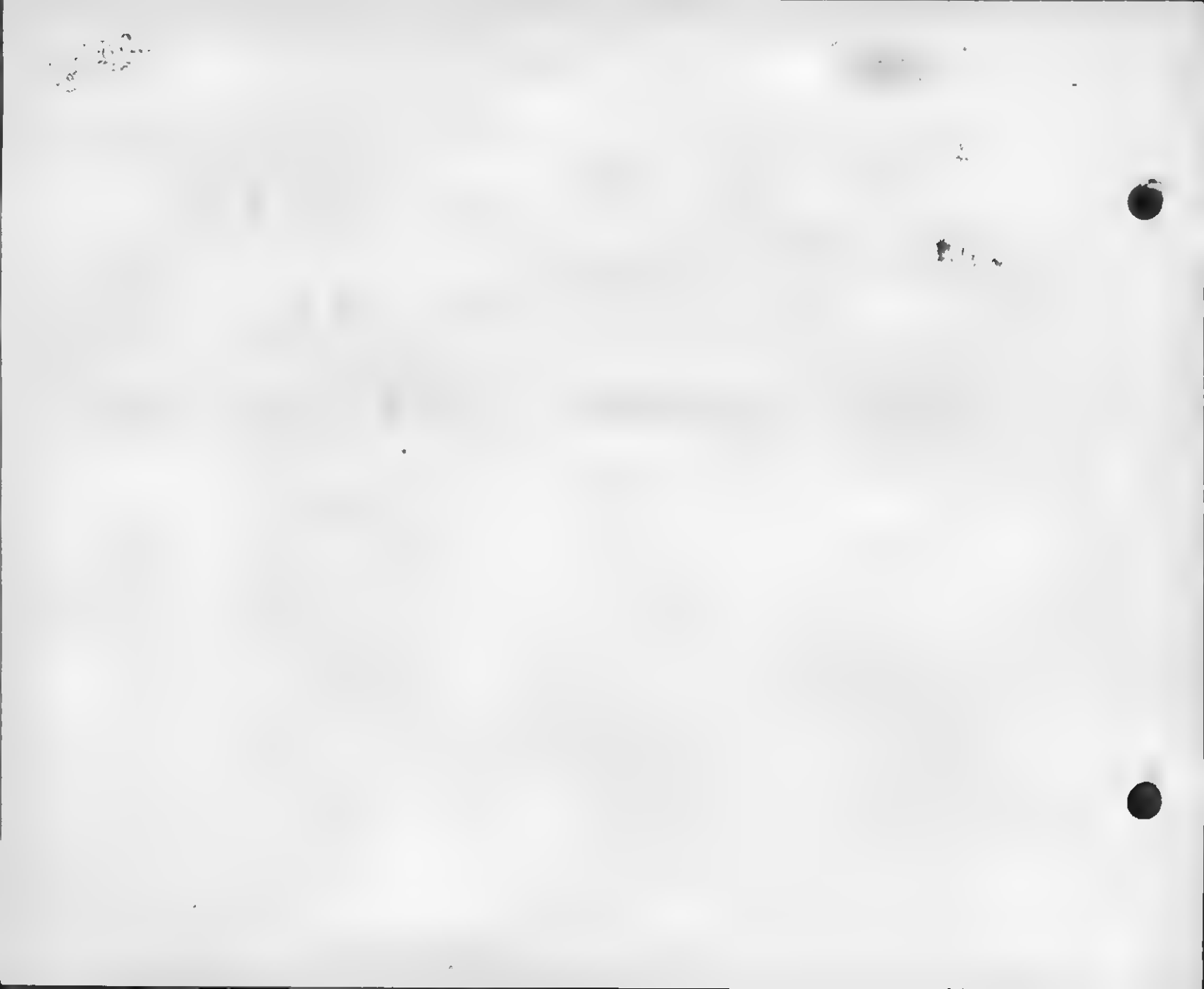
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06801

CERTIFICATE OF DEATH

06788

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a STATE <u>md.</u> b COUNTY <u>Mont.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda L.O.A.</u>				c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d STREET ADDRESS <u>306 Park Rd</u>		e IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Eleanor Bernice Atwood</u> First Middle Last				4 DATE OF DEATH <u>5-26-67</u> Month Day Year			
5 SEX <u>F</u>		6 CO. OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12-5-1900</u> 66 YEARS MONTHS DAYS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Indiana</u>	
12 CITIZENSHIP <u>U.S.A.</u>				13 MOTHER'S NAME <u>Frances Julia Murphy</u>			
14 MOTHER'S MAIDEN NAME				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO				17 INFORMANT <u>Charles P. Atwood - husband - same #2</u> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>2 1/2 YRS</u> <u>2 1/2 YRS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour am p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f City or town				20g State			
21 I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1952</u> to <u>MAY 27 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 22 1967</u> , and that death occurred at <u>1:50 PM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Gordon S. Rosenberger</u> M.D.				22b DATE SIGNED <u>MAY 26 1967</u>		22c PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>	
22d ADDRESS <u>310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND</u>				22e ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input type="checkbox"/>			
23a BURIAL, CREMATION, or other disposition		23b DATE THEREOF <u>5/29/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d LOCATION (City or town, county, state) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				25a REC'D BY REG. STRA. <u>MAY 29 1967</u>		25b REG. STRA.'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

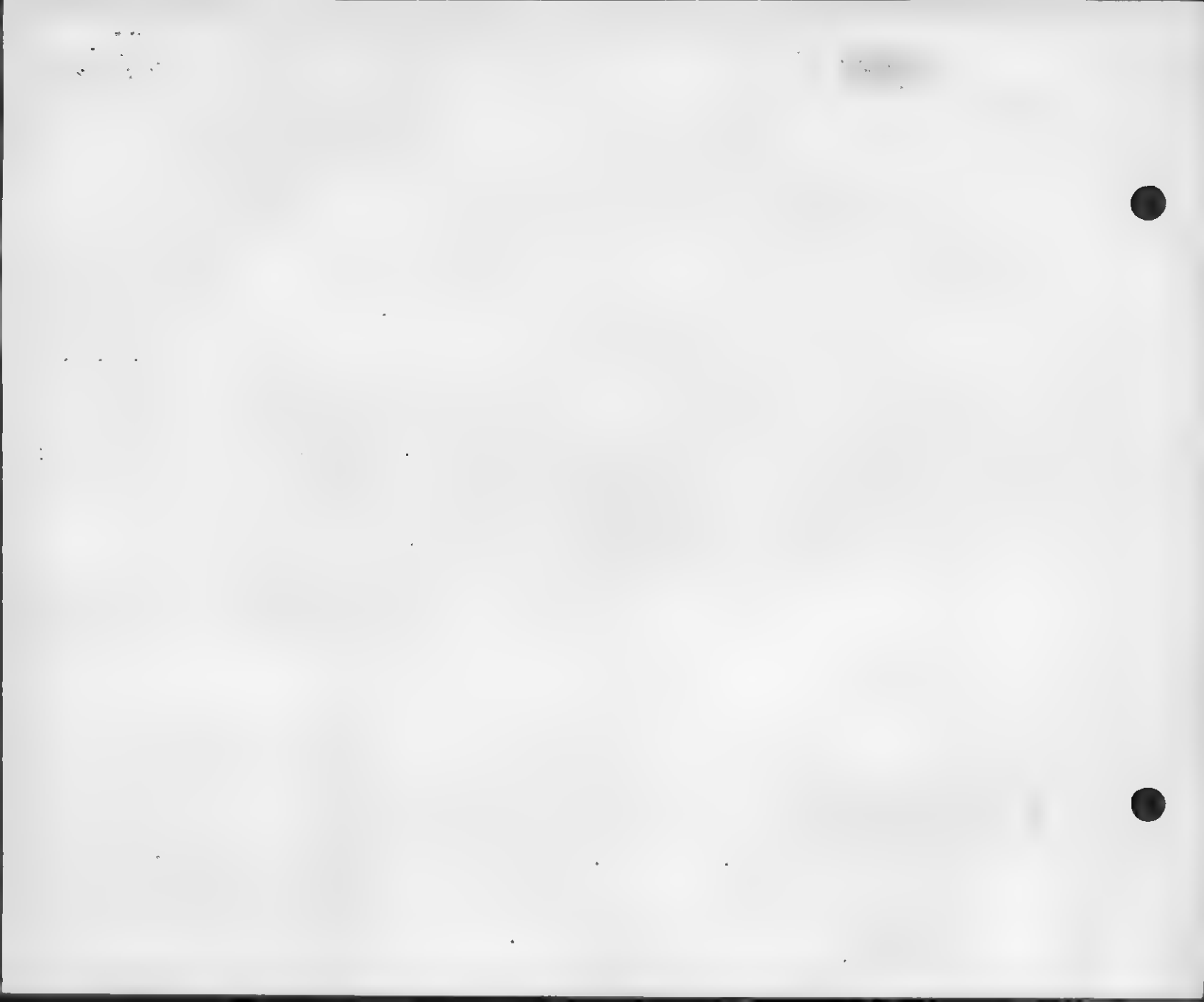
06802

CERTIFICATE OF DEATH

06789

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE TEXAS b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL			c LENGTH OF STAY IN TB 47 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YORKTOWN		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETHESDA, MARYLAND						d STREET ADDRESS e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Lorraine Constance AUDILET				4 DATE OF DEATH Month Day Year MAY 30 1967			
5 SEX FEMALE		6 COLOR OR RACE CAUC		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH August 26, 1932	
9 AGE (In years birthday) yrs 34		10 F UNDER 1 YEAR Months Days 30 9		11 IF UNDER 24 HRS Hours Min 67			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b KIND OF BUSINESS OR INDUSTRY School Teacher		11 BIRTHPLACE (County & State or foreign country) Laurel, Maryland	
12 CITIZEN OF WHAT COUNTRY U. S. A.							
13 FATHER'S NAME William Carter CRONMILLER				14 MOTHER'S MAIDEN NAME Euphanie Helen STONER			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16 SOCIAL SECURITY NO 214 28 4889		17 INFORMANT Address Ward T-11 Garland O. AUDILET, Naval Hospital, Bethesda, Md.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis Lung and Bone Marrow from DUE TO Primary Cancer of the Breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WA AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that () (th) s hospital attended the deceased from April 14, 1967 to 30 April 1967 , that (s) (we) last saw the deceased alive on 30 May 1967 and that death occurred at 1155AM , from causes and on the date stated above.							
22a SIGNATURE <i>Theodore H. Wilson Jr.</i>				22b DATE SIGNED 31 May 1967		22c PHYSICIAN'S NAME (Type) Theodore H. Wilson Jr.	
22d ADDRESS Naval Hospital, Bethesda, Maryland							
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF June 2, 1967		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia		23d LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR CUNNINGHAM FUNERAL HOME, Cameron and N. Alfred Alexandria, Virginia B. E. Mountcastle				25a REC'D BY REGISTRAR JUN 2 1967		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

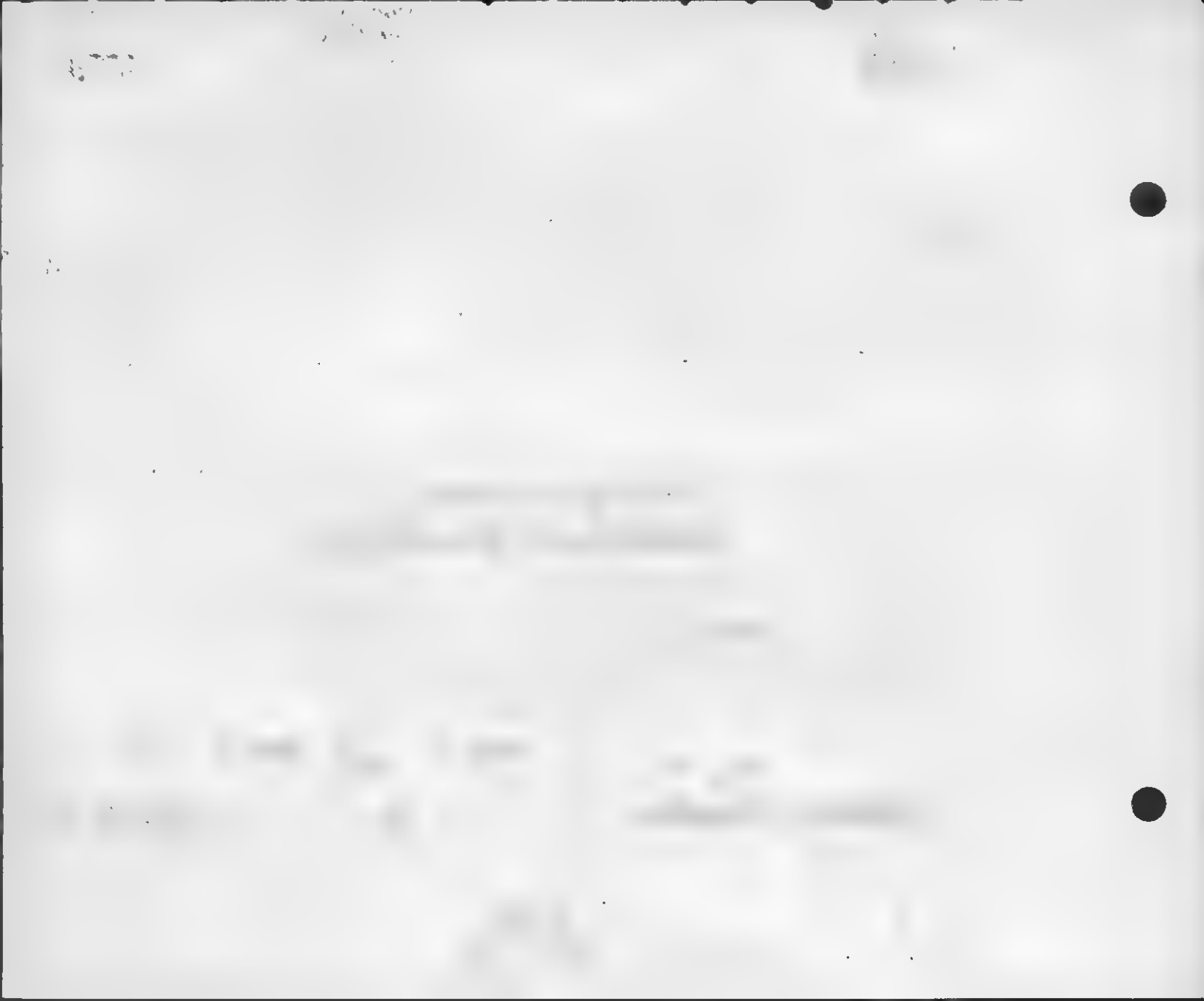
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

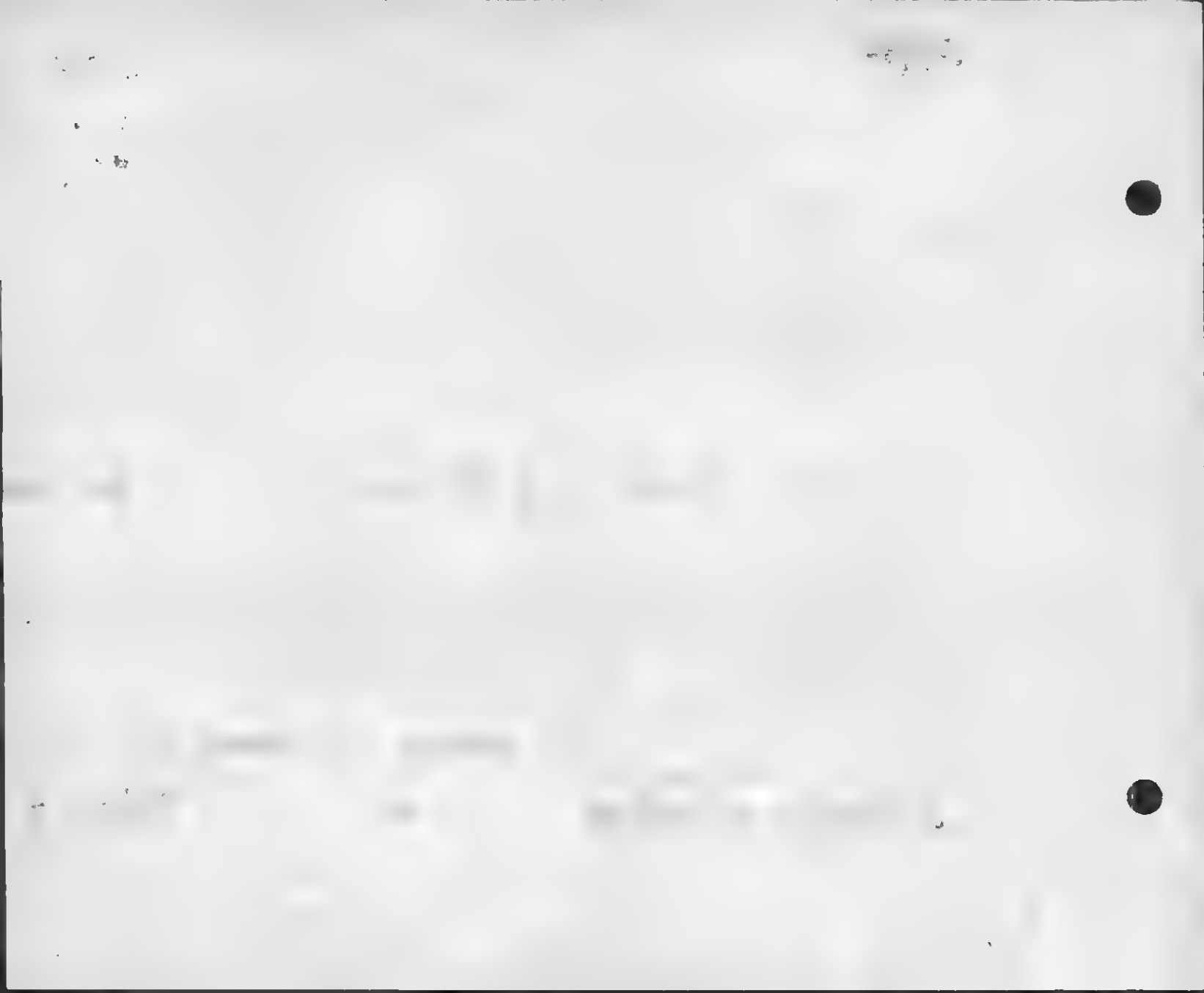
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
06803						06790							
1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7800 Muncaster Hill Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7800 Muncaster Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Croft</u> Middle <u>Ann</u> Last <u>Andrae</u>						4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1900</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>15</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				
13. FATHER'S NAME <u>Charles Aufenthie</u>						14. MOTHER'S MAIDEN NAME <u>Augusta Bergman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-23-456789</u>		17. INFORMANT <u>Charles M. Andrae, 7800 Muncaster Hill Road</u>			Address <u>Bethesda, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>None</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May 31, 1967</u> to <u>May 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 31, 1967</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>William C. Whetten</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 31, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>William C. Whetten, M.D.</u>						22d. ADDRESS <u>1137 N. Frederick St. Gaithersburg, Md. 20878</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>6-2-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>			23d. LOCATION (City, town or county) (State) <u>WASH. D.C.</u>				
24. FUNERAL DIRECTOR <u>Hawley Funeral H.</u>				ADDRESS <u>4745 Wisc. Ave.</u>		25a. REC'D BY REGISTRAR <u>JUN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06804													
06791													
1. PLACE OF DEATH a. COUNTY <u>IT</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>IT</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>IT</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>IT</u>						d. STREET ADDRESS <u>IT</u>							
3. NAME OF DECEASED (Type or print) First <u>IT</u> Middle <u>IT</u> Last <u>IT</u>						4. DATE OF DEATH Month <u>IT</u> Day <u>IT</u> Year <u>19</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>IT</u>		9. AGE (In years last birthday) <u>IT</u> yrs.		IF UNDER 1 YEAR Months <u>IT</u> Days <u>IT</u> Hours <u>IT</u> Min. <u>IT</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Andrew W. Sparks</u>						14. MOTHER'S MAIDEN NAME <u>Mary J. King</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>						16. SOCIAL SECURITY NO. <u>IT</u>		17. INFORMANT <u>IT</u> Address <u>IT</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis of Arteries</u> DUE TO (b) <u>IT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>IT</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>IT</u>												INTERVAL BETWEEN ONSET AND DEATH <u>4-5 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>IT</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>18 April, 1967</u> to <u>15 May, 1967</u> , that (I) (we) last saw the deceased alive on <u>15 May, 1967</u> , and that death occurred at <u>IT</u> M, from the causes <u>IT</u> and on the date stated above.													
22a. SIGNATURE <u>William D. King</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/15/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>IT</u>						22d. ADDRESS <u>IT</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>IT</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR <u>Glen Carter</u>						ADDRESS <u>IT</u>		25a. REC'D BY REGISTRAR <u>IT</u>		25b. REGISTRAR'S SIGNATURE <u>IT</u>			
MAY 18 1967													



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06805

06792

1. PLACE OF DEATH a. COUNTY <u>Monterey</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>4006 S. 2nd St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>13.000</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/67</u>
9. AGE (in years last birthday) <u>0</u> yrs.		10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	10. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B. ...</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Mandley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Dorothy Bacon Mother</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choked</u> DUE TO <u>Maternal asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Asphyxia</u> DUE TO <u>Asphyxia</u> (c) <u>Asphyxia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 21, 1967</u> to <u>May 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 21, 1967</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>May 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>5011 Georgia Ave.</u>		22d. ADDRESS <u>Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-29-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Ave.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE <u>May 29 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

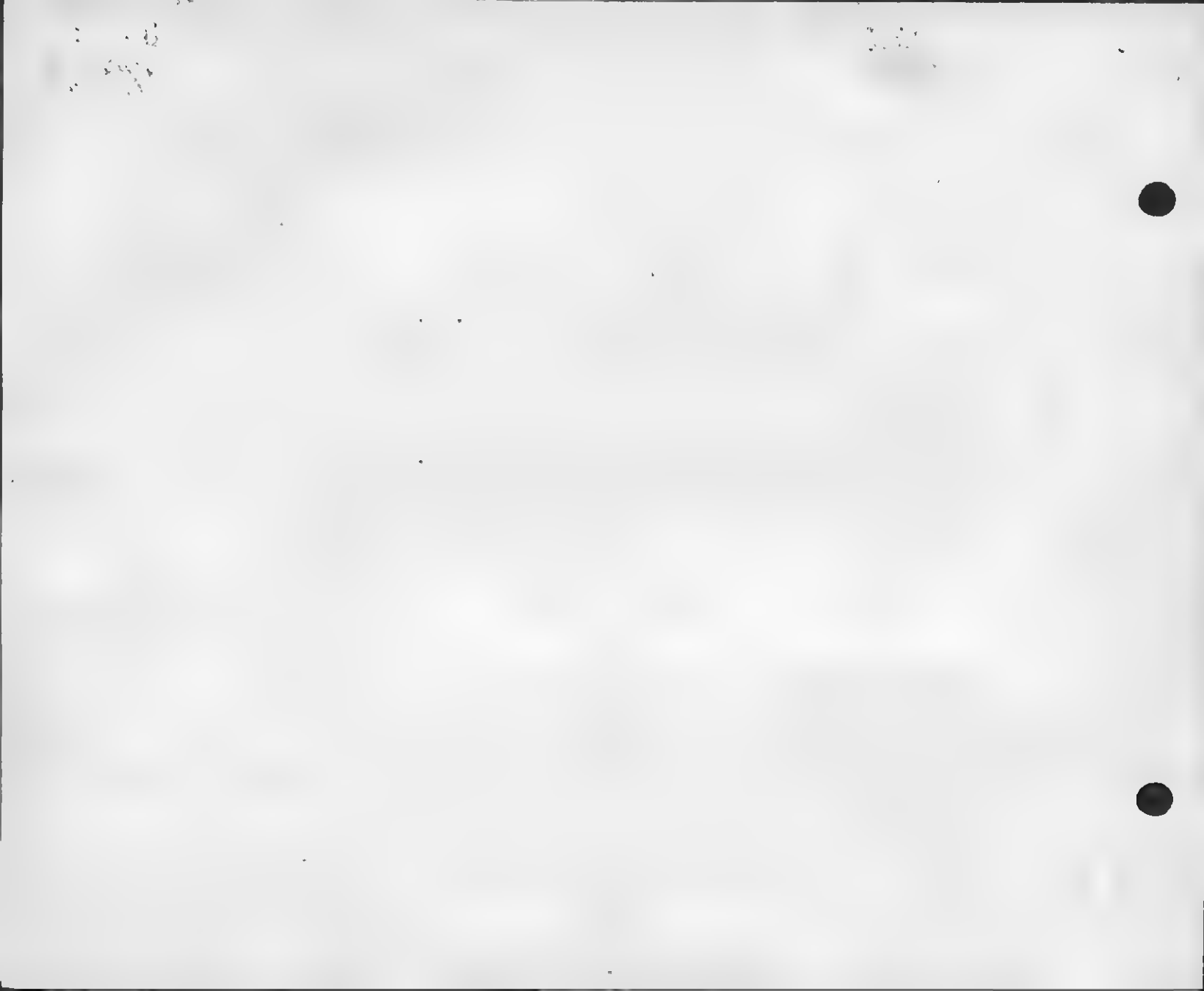
06806

CERTIFICATE OF DEATH

06793

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived first 1 yr or Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 403 Anderson Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY F. BAKER		4. DATE OF DEATH May 30, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1886
9 AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (County & State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Reuben Baker		14 MOTHER'S MAIDEN NAME Mary Belt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 217-36-7275	
17 INFORMANT Ellen L. Baker-Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 5/11/1967 to 5/30/1967 that (I) (we) last saw the deceased alive on 5/30/1967 and that death occurred at Rockville, Md from causes and on the date stated above			
22a SIGNATURE Stephen N. Jones		22b DATE SIGNED 5/30/67	
22c PHYSICIAN'S NAME (Type) Stephen N. Jones		22d ADDRESS Rockville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6/2/67	23c NAME OF CEMETERY OR CREMATORY Parklawn	23d LOCATION (City or Town) (County) (State) Rockville, Md.
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		25a REC'D BY REGISTRAR UN 1 1967	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06807

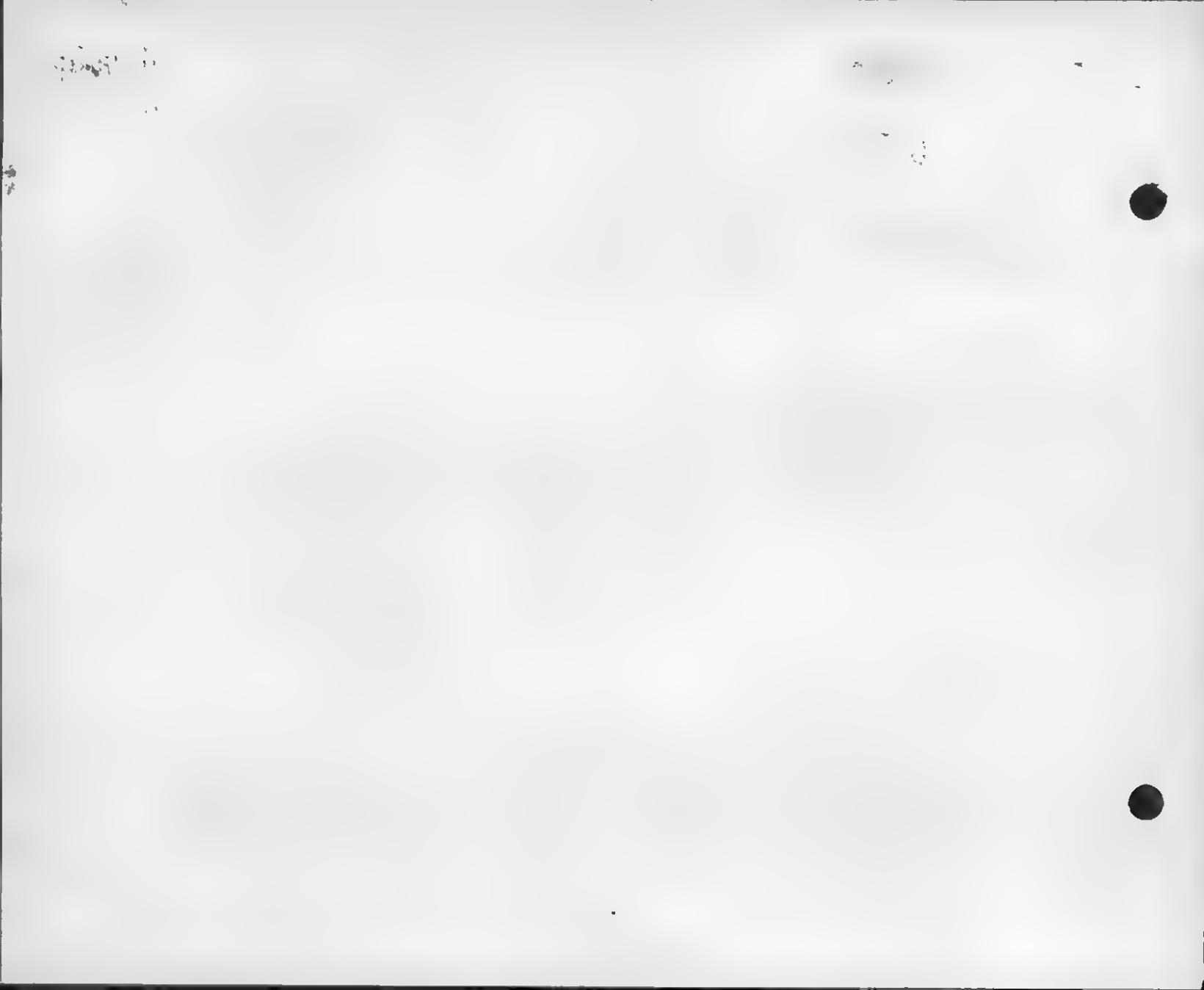
CERTIFICATE OF DEATH

06794

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c LENGTH OF STAY N b <u>44 Days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>				d STREET ADDRESS <u>4409 Stanford Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <u>Helena</u> <u>Stanislawa</u> <u>Banczyk</u>				4 DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1967</u>				
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>April 6, 1910</u>		
9 AGE (In years, last birthday) <u>57</u> yrs		10 UNDER 1 YEAR Months <u> </u> Day <u> </u>		11 UNDER 24 HRS Hours <u> </u> Min <u> </u>				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>								
13 FATHER'S NAME <u>Karol Wilczynski</u>				14 MOTHER'S MAIDEN NAME <u>Zofja Wojciechowska</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pseudomonas Pneumonia and Septicemia</u> DUE TO <u>Leukemia</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Blastic Transformation of Chronic Myelogenous Leukemia</u> DUE TO (c) <u>Chronic Myelogenous Leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>40 Days</u> <u>Weeks</u> <u>10 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS A OPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)				
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f CITY OR TOWN (County) (State)		
21 I certify that <u>she</u> (this hospital) <u>attended the deceased from April 17, 1967, to May 31, 1967 that I (we) first saw the deceased alive on May 31, 1967, and that death occurred at 6:55 PM, from causes and on the date stated above</u>								
22a SIGNATURE <u>Martin H. Cohen</u>				22b DATE SIGNED <u>June 1, 1967</u>		22c ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>		
22c PHYSICIAN'S NAME (Type) <u>Martin Cohen, M. D.</u>								
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>6-3-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		



06805

06795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

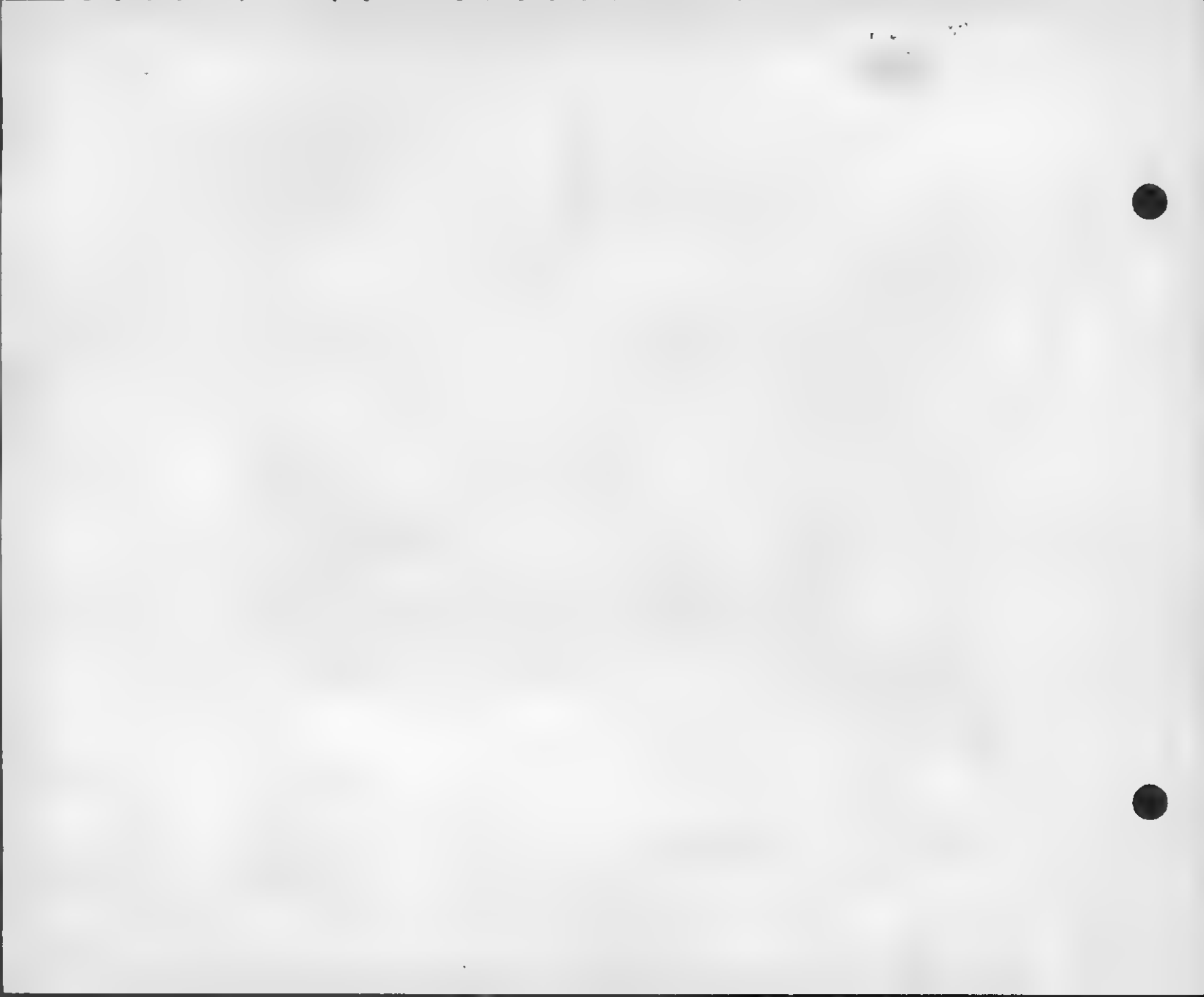
100

100



VR A15 (4)
25M 1/67

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c LENGTH OF STAY IN the 5-8-67 to 5-8-67		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring						
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. + Hospital		d STREET ADDRESS 602 Lanark Way e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) MADLYN AMELIA BARCLAY		4 DATE OF DEATH Month MAY Day 8 Year 1967						
5 SEX Female	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-21-00	9 AGE (In years last birthday) 66 yrs	10 F UNDER 1 YEAR Months 6	11 IF UNDER 24 HRS Days 8	12 HOURS 19	13 MIN 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (County & State or foreign country) ENGLAND		12 CITIZEN OF WHAT COUNTRY UNITED STATES		
13 FATHER'S NAME Joseph S. Hancox				14 MOTHER'S MAIDEN NAME Emma ?				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16 SOCIAL SECURITY NO. 7-72-1		17 INFORMANT HUSBAND 602 Lanark Way, S.S., Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) chronic cardiovascular & hypertensive disease DUE TO (c) hypertensive disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19 WAS A COPY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 1B)						
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from January 1962 to May 8, 1967 , that (I) (we) lost saw the deceased alive on May 8, 1967 , and that death occurred at 4:30 PM , from causes and on the date stated above								
22a SIGNATURE Burt Johnson 22c PHYSICIAN'S NAME (Type) Burt Johnson				M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b DATE SIGNED 5-8-67		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF May 12, 1967		23c NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d LOCATION (City or Town) (County) (State) Silver Spring, Md.		
24 FUNERAL DIRECTOR John B. Jones		ADDRESS 1000 Silver Spring, Md.		25a REC'D BY REGISTRAR John B. Jones		25b REGISTRAR'S SIGNATURE John B. Jones		
DATE MAY 11 1967								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06810

CERTIFICATE OF DEATH

06797

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Montgomery			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c LENGTH OF STAY IN 1b 2 weeks		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d STREET ADDRESS 6100 Swansea Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last BELLE WALTON BARNES				4 DATE OF DEATH Month Day Year May 30, 1967			
5 SEX Female	6 CO. OR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH May 5, 1895	9 AGE (In years past birthday) 72 yrs	F UNDER 1 YEAR Months Days Hours Mm	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Edward Walton				14 MOTHER'S MAIDEN NAME Ella Olivia Johns			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-44-8510B		17 INFORMANT Husband Address Same as Item 2. William W. Barnes			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno Carcinoma of the DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transverse Colon Ca metastases DUE TO (c) 2 month						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Hour o m p m 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1, 1964 , to 5/30, 1967 , that (I) (we) last saw the deceased alive on 5/30, 1967 , and that death occurred at 1:30 PM , from causes on and on the date stated above.							
22a SIGNATURE Donald Q. Ekman				22b DATE SIGNED 5-31-67		22c PHYSICIAN'S NAME (Type) DONALD Q. EKMAN	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6-2-67		23c NAME OF CEMETERY OR CREMATORY Washington Natl Cem.		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland				25a REC'D BY REGISTRAR DATE JUN 5 1967		25b REGISTRAR'S SIGNATURE John J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06817

CERTIFICATE OF DEATH

06798

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2615 W...</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>2615 Wisconsin Ave. N.W.</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Silver Manor Health Care Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4 NAME OF DECEASED (Type or print) First <u>Jose</u> Middle <u>T.</u> Last <u>BARON</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 6, 1953</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Diplomat</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	9 AGE (In years last birthday) <u>8.9</u> yrs
11 FATHER'S NAME <u>Carlos Baron</u>		12 CITIZEN OF WHAT COUNTRY? <u>CUBA</u>	
13 MOTHER'S MAIDEN NAME <u>Clotilde Valdez</u>		14 ADDRESS <u>See Item #2</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16 SOCIAL SECURITY NO. <u>- -</u>	
17 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis of the heart and blood vessels</u> DUE TO (c) <u>Coronary Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		18 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> pm		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (i) (this hospital) attended the deceased from <u>Jan 1, 1953</u> to <u>May 7, 1967</u> that (i) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Donald E. Jones</u>		22b DATE SIGNED <u>5 8 67</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-10-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Pauline Inc. Wash. D.C.</u>		25a REC'D BY REG. STR. <u>MAY 10 1967</u> 25b REG. STR.'S SIGNATURE <u>William J. Jones</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

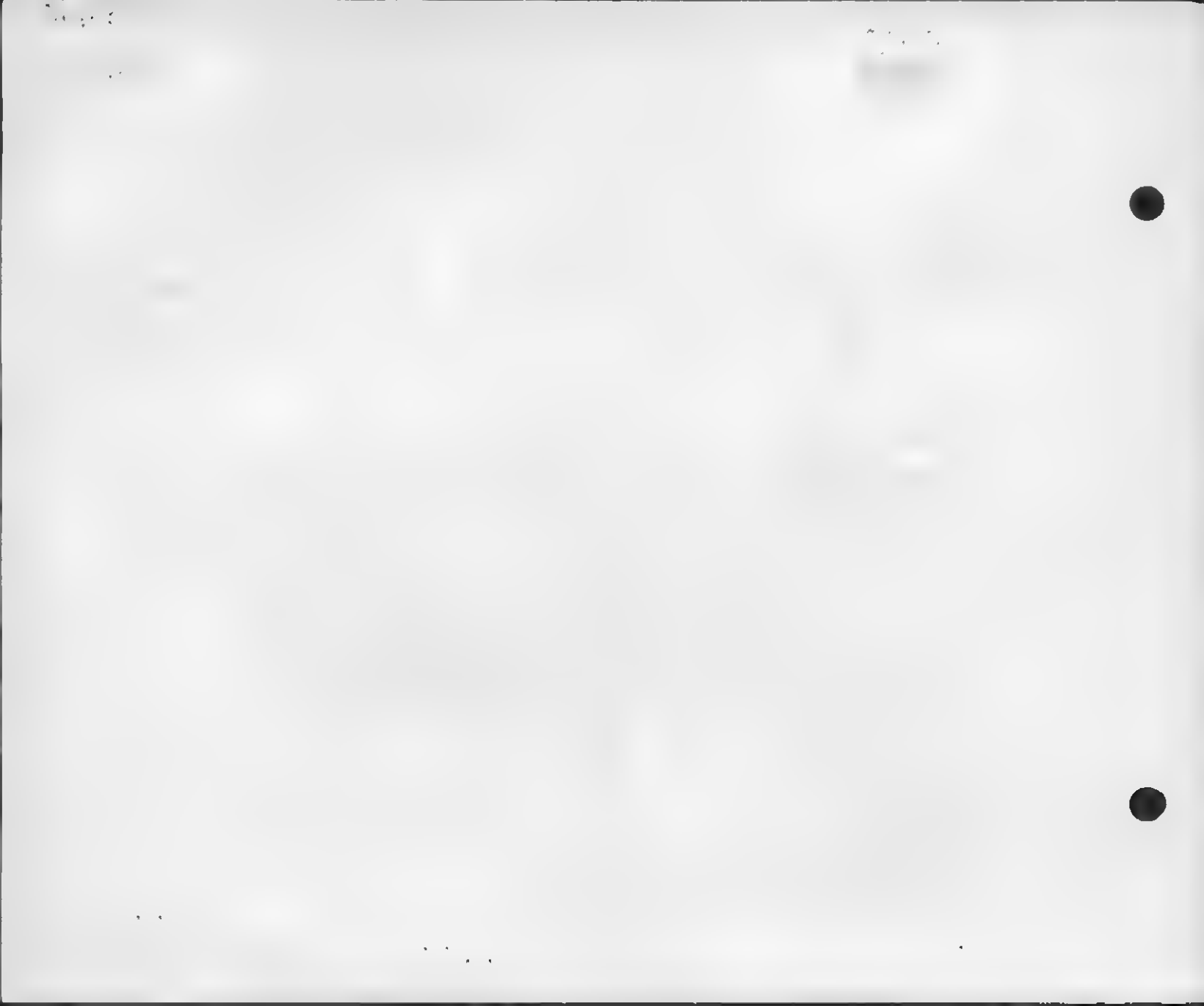
06812

CERTIFICATE OF DEATH

06799

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

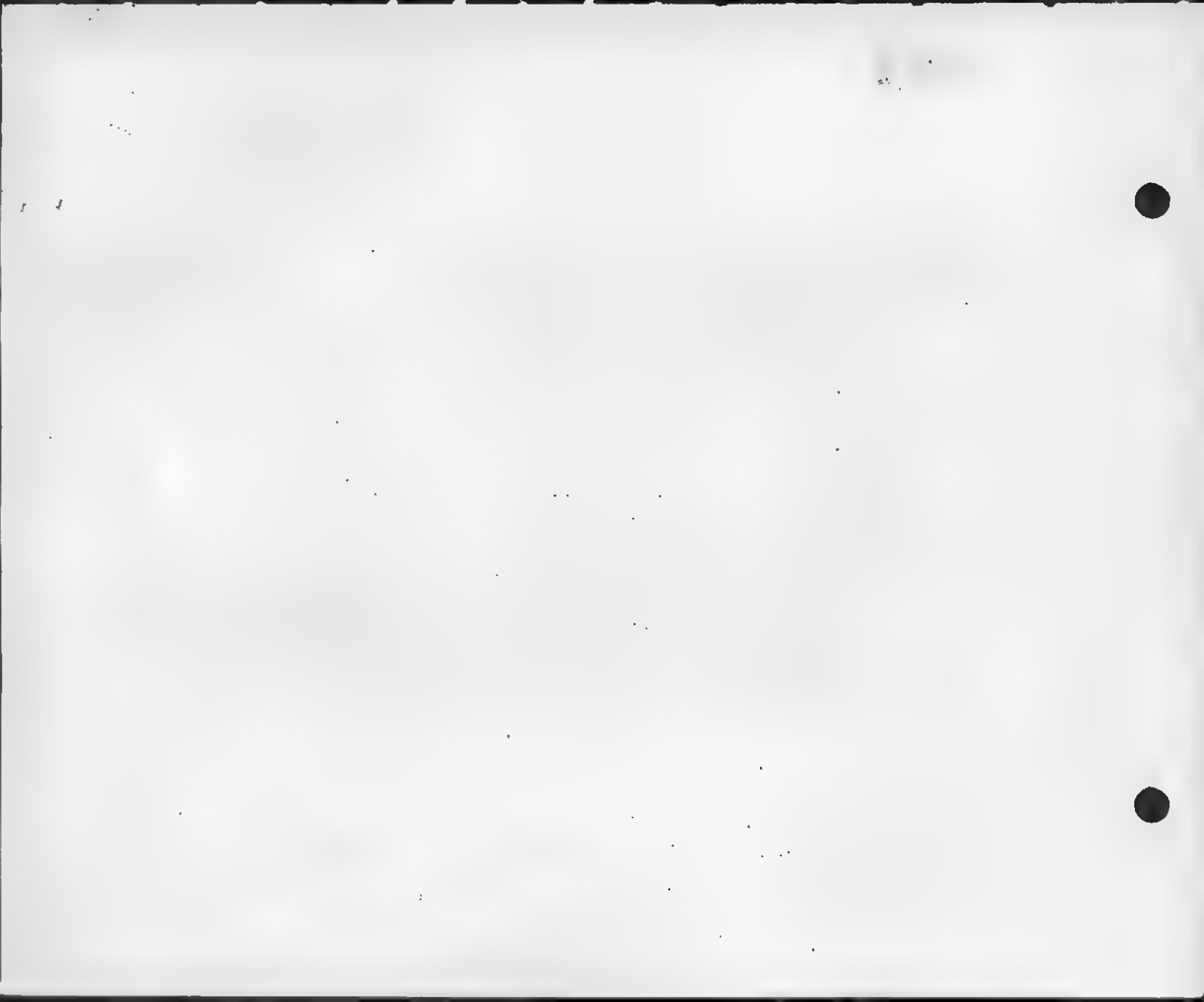
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>142 2 mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kensington GARDENS SAN.</u>		e. STREET ADDRESS <u>8401 Manchester Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MADE H Barrett</u>		4. DATE OF DEATH Month Day Year <u>May 31 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1896</u>
9 AGE (In years lost b rthday) <u>71</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY <u>CLEANING</u>
11 BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles G Barrett</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>214-03-8383</u>	
17 INFORMANT <u>ma B Barrett</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> DUE TO (b) <u>Arterio sclerotic disease</u> DUE TO (c) <u>Coronary arteriosclerotic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19 WA AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>pm</u> <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>19</u> - to <u>19</u> . That (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>6/1/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS		25a REC'D BY REGISTRAR DATE <u>JUN 5 1967</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: right;">06800</div> <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>4 mths</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>105 Harrington Drive</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Miss.</i> b. COUNTY <i>Newton</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Newton</i> d. STREET ADDRESS <i>—</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Raybon Felix Bassett</i> First <i>Raybon</i> Middle <i>Felix</i> Last <i>Bassett</i>			4. DATE OF DEATH <i>May 22</i> 19 <i>67</i> Month <i>May</i> Day <i>22</i> Year <i>1967</i>			5. SEX <i>Male</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>Aug. 17, 1888</i> 9. AGE (in years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i> IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Floor Layer</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Mississippi</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>				13. FATHER'S NAME <i>James Harford Bassett</i> 14. MOTHER'S MAIDEN NAME <i>Lula Burnside</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>427 01 1581A</i> 16. SOCIAL SECURITY NO. <i>427 01 1581A</i> 17. INFORMANT <i>Mr. Clifford Rayne</i> Address <i>105 Harrington Dr. SS</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial D.C.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myocardial D.C.</i> DUE TO (c) <i>Generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>—</i>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i> 20c. TIME OF INJURY Month, Day, Year <i>May 22, 1967</i> Hour a.m. <i>—</i> p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i> 20f. (City or town) (County) (State) <i>Newton Mississippi</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <i>May 22, 1967</i> to <i>May 22, 1967</i> that (I) (we) last saw the deceased alive on <i>May 22, 1967</i> and that death occurred at <i>8:00 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Charles O. Rogers, M.D.</i> 22c. PHYSICIAN'S NAME (Type) <i>Charles O. Rogers, M.D.</i>						22b. DATE SIGNED <i>May 23, 1967</i> 22d. ADDRESS <i>1719 S. ...</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>May 26, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Knight's of Pythias Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Newton Mississippi</i>				24. FUNERAL DIRECTOR <i>Arthur R. ...</i> ADDRESS <i>254 Carroll Hill Rd. H.C.</i> 25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE DATE <i>MAY 23 1967</i>							



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If any delay is
 TO FUNERAL DIRECTOR: Page 4 of 4, with the ward pending a permit in form 18. Give Part 1, 2, and 3 to
 TO FUNERAL DIRECTOR: Page 4 of 4, with the ward pending a permit in form 18. Give Part 1, 2, and 3 to
 TO FUNERAL DIRECTOR: Page 4 of 4, with the ward pending a permit in form 18. Give Part 1, 2, and 3 to

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06814

06801

PLACE OF DEATH
CITY

Montgomery

MARYLAND

Michigan

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural)

LENGTH OF STAY IN
65 days

CITY OR TOWN (If outside corporate limits, write RURAL)
Detroit

NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)
Naval Hospital,

STREET ADDRESS
8120 East Jefferson St., Apt. 5H

NAME OF DECEASED
SEX

Michael

C.

BAUM

DATE OF DEATH

May

4

19 67

Male

Cauc

WIDOWED

D VORCED

DATE OF BIRTH
Sept. 17, 1944

22

19 67

QUALIFICATION IN (If not at work done during most of working life, ever first reg)
U.S. Marine Corps

CL. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State and County)
Washington, D. C.

IF BORN IN WHAT COUNTRY?
USA

FATHER NAME

Edgar Baum

MOTHER'S MAIDEN NAME

Betty Ann Ludwig

WAS DECEASED EVER IN U.S. ARMED FORCES
Yes

1963-1965

SECURITY NO
372 46 1047

INFORMANT
Mr. Edgar Baum, 6803 Shepherd St.

Address Maryland

CAUSE OF DEATH
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE

Meningitis

CONDITIONS (if any, which gave rise to immediate cause or stating the underlying cause lost)

DUE TO
DUE TO
(c)

Head injury from auto accident

//about 5 days
3 months

PART II OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (IN CASE GIVEN IN PART I)

EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

WHEN DESCRIBE HOW INJURY OCCURRED (Include time, place, Port or Port of Entry, if applicable)
When driving lost control of car, ran off road

Lothian

Md.

TIME OF INJURY (Month, Day, Year)
2:45 pm

19 67

at work

not work

street

Wayson's Corner/ Anne Arundel

I certify that, to the best of my knowledge and belief, the information described above is true and correct.
 Death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Other ☐

ACTUAL SIGNATURE
EXAMINER'S NAME

John G. Ball
John G. Ball, M. D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

5 May 1967

Burial

May 6, 1967

Arlington National

Arlington, Virginia

24 FUNERAL DIRECTOR
W. W. Chambers Co.
1400 Chapin Street, N.W., Washington, D. C.

MAY 11 1967
Charles Judge



06815

VR A15 (4)
25M 1/67



7 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06816

06803

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admision) a STATE MARYLAND b COUNTY MONTGOMERY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD.			c LENGTH OF STAY IN 1b 2 months		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RESNOR SANITARIUM & HOSPITAL			d STREET ADDRESS 1211 Woodside Parkway		
3 NAME OF DECEASED (Type or print) Sarah B. Bentley			4 DATE OF DEATH Month May Day 17 Year 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 27 Nov. 1877	9 AGE (In years last birthday) 89 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Veterans Administration		11 BIRTHPLACE (County & State or foreign country) Washington, D.C.	
13 FATHER'S NAME Orlando R. Doteler			14 MOTHER'S MAIDEN NAME Mary J. Miller		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, if unknown) No None		16 SOCIAL SECURITY NO 579-60-4849		17 INFORMANT Mrs. J. Reginald Boyd	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY 331X IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO (b) Chronic Coronary Disease DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 1 hr			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		20g (County)		20h (State)	
21 I certify that (I) (this hospital) attended the deceased from June 17, 1967 to May 17, 1967 , that (I) (we) last saw the deceased alive on May 17, 1967 , and that death occurred at 12:15 PM from causes and on the date stated above					
22a SIGNATURE William Luckett		22b DATE SIGNED 5/17/67		22c ADDRESS 5000 Reno Rd., N. W., Washington, D. C.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF May 19, 1967		23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d LOCATION (City or town) Washington, D. C.		23e LOCATION (County) D. C.		23f LOCATION (State) D. C.	
24 FUNERAL DIRECTOR Glen Carter		24b ADDRESS 8434 Georgia Avenue		25a REC'D BY REGISTRAR MAY 19 1967	
24c NAME Warner E. Purphrey, Inc.		24d ADDRESS Silver Spring, Md.		25b REGISTRAR'S SIGNATURE Charles J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06804

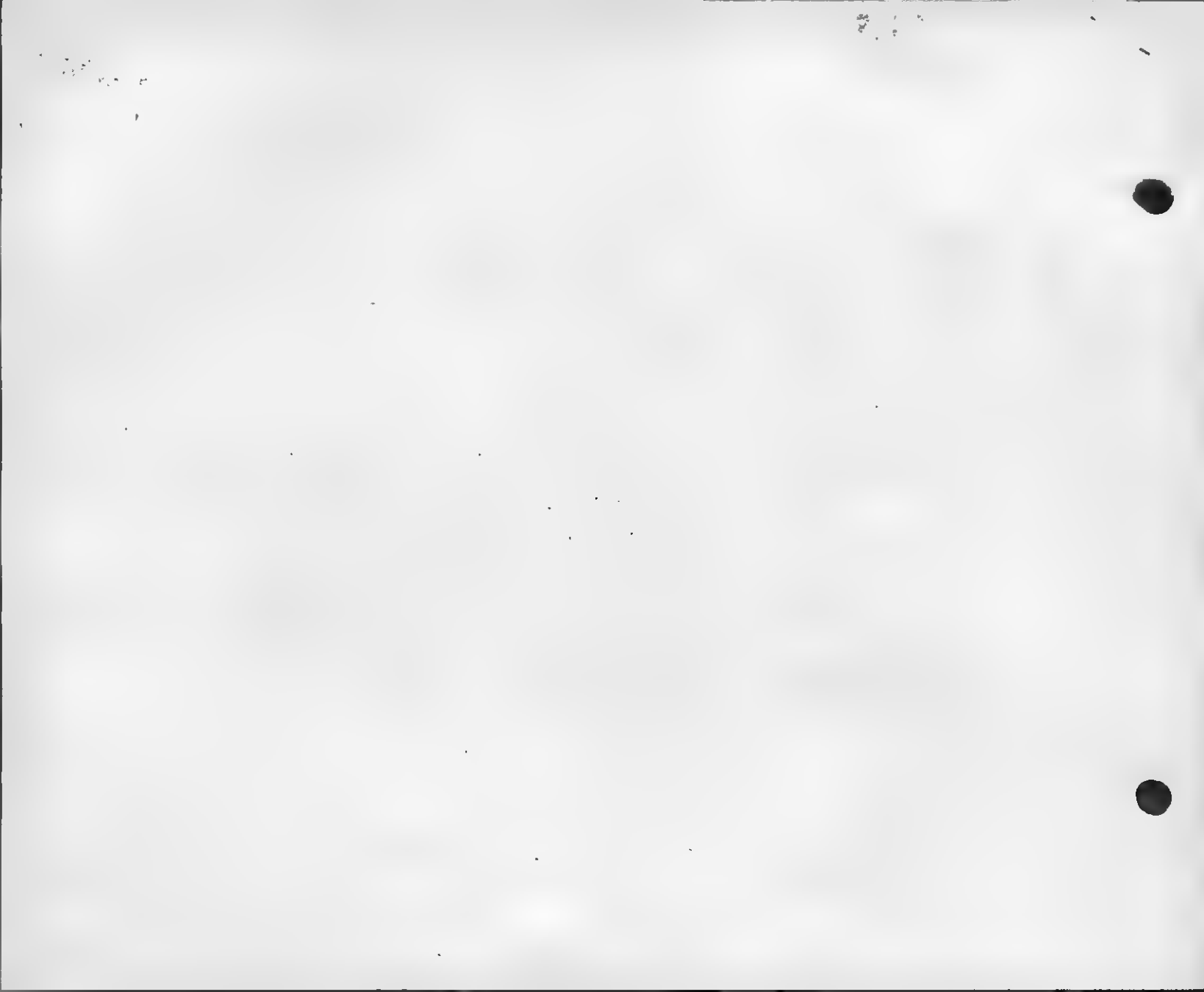
06817

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE California b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY N 1b 36 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach		d. STREET ADDRESS 3506 California Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last GUSTAV CONRAD BERG		4 DATE OF DEATH Month Day Year MAY 25 19 67	
5 SEX MALE	6 COLOR OR RACE CAUC	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 22 OCT 1900
9 AGE (in years last birthday) 66 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAVY	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Sweden	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Gustav Berg	
14 MOTHER'S MAIDEN NAME unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1916-45	
16 SOCIAL SECURITY NO 573 36 6580		17 INFORMANT Long Beach Address Calif. Mrs. Evelyn L. Berg, 3506 California Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pancreatitis, acute necrotizing DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peptic ulcer disease (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 28 , 19 67 , to May 25 , 19 67 , that (I) (we) last saw the deceased alive on May 25 , 19 67 , and that death occurred at 500A M , from causes and on the date stated above.			
22a. SIGNATURE Theodore H. Wilson, Jr. M.D.		22b. DATE SIGNED May 25, 1967	
22c. PHYSICIAN'S NAME (Type) Theodore H. Wilson, Jr., M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-29-67	23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Memorial Park	23d. LOCATION (City or Town) (County) (State) Cypress, California
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR MAY 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

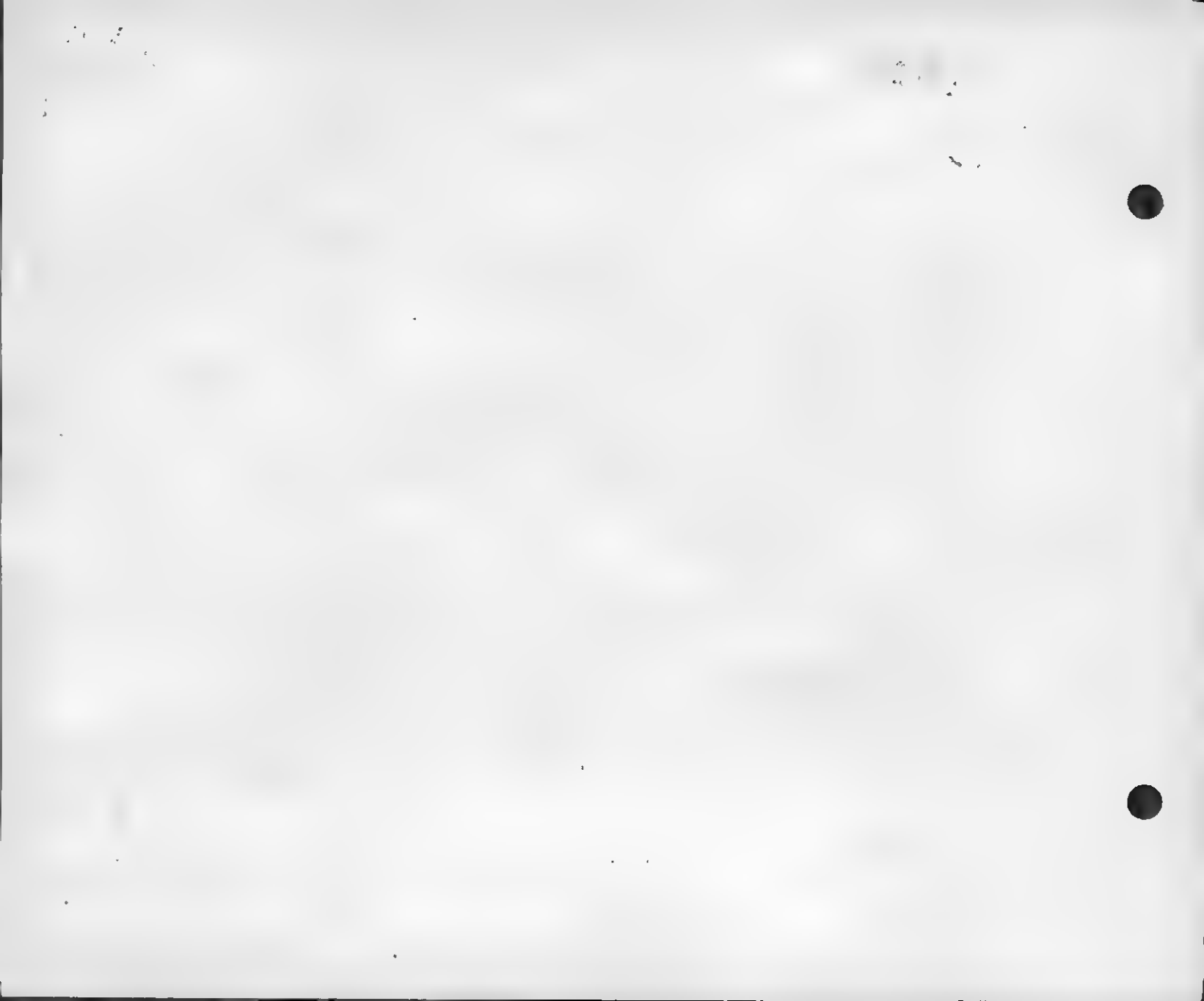
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06815

CERTIFICATE OF DEATH

06805

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural) c LENGTH OF STAY IN b 3 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY LAUREL c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15709 BRADFORD DRIVE	
3 NAME OF DECEASED (Type or print) First Middle Last ANNE BEATRICE BERGERE		4 DATE OF DEATH Month Day Year MAY 11 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAUC	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 DEC. 1889
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b KIND OF BUSINESS OR INDUSTRY	9c AGE (In years last birthday) 77 yrs
10a USUAL RESIDENCE (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY	10c AGE (In years last birthday) 77 yrs
11 BIRTHPLACE (County & State or foreign country) BROOKLYN, N.Y.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME (UNKNOWN) FEENEY		14 MOTHER'S MAIDEN NAME (UNKNOWN) BYRNES	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO UNKNOWN	
17 INFORMANT WARREN E BERGERE		Address LAUREL MD. 15709 BRADFORD DRIVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myxedema X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town, county, state)
21. I certify that (I) (this hospital) attended the deceased from 8 MAY 19 67 to 11 MAY 19 67 that (I) (we) last saw the deceased alive on 11 MAY 19 67 , and that death occurred at 12:36 AM from causes and on the date stated above.			
22a SIGNATURE  22c PHYSICIAN'S NAME (Type) D. R. Foreman, M. D.		22b DATE SIGNED 12 May 1967	
23a BLURIAL CREMATION REMOVAL (Specify) BURIAL		23b DATE THEREOF MAY 15, 1967	
23c NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d LOCATION (City or town) (County) (State) BROOKLYN N.Y.	
24 FUNERAL DIRECTOR W. W. CHAMBERS		25a REC'D BY REG. STRAR MAY 15 1967	
25b REGISTRAR'S SIGNATURE 			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

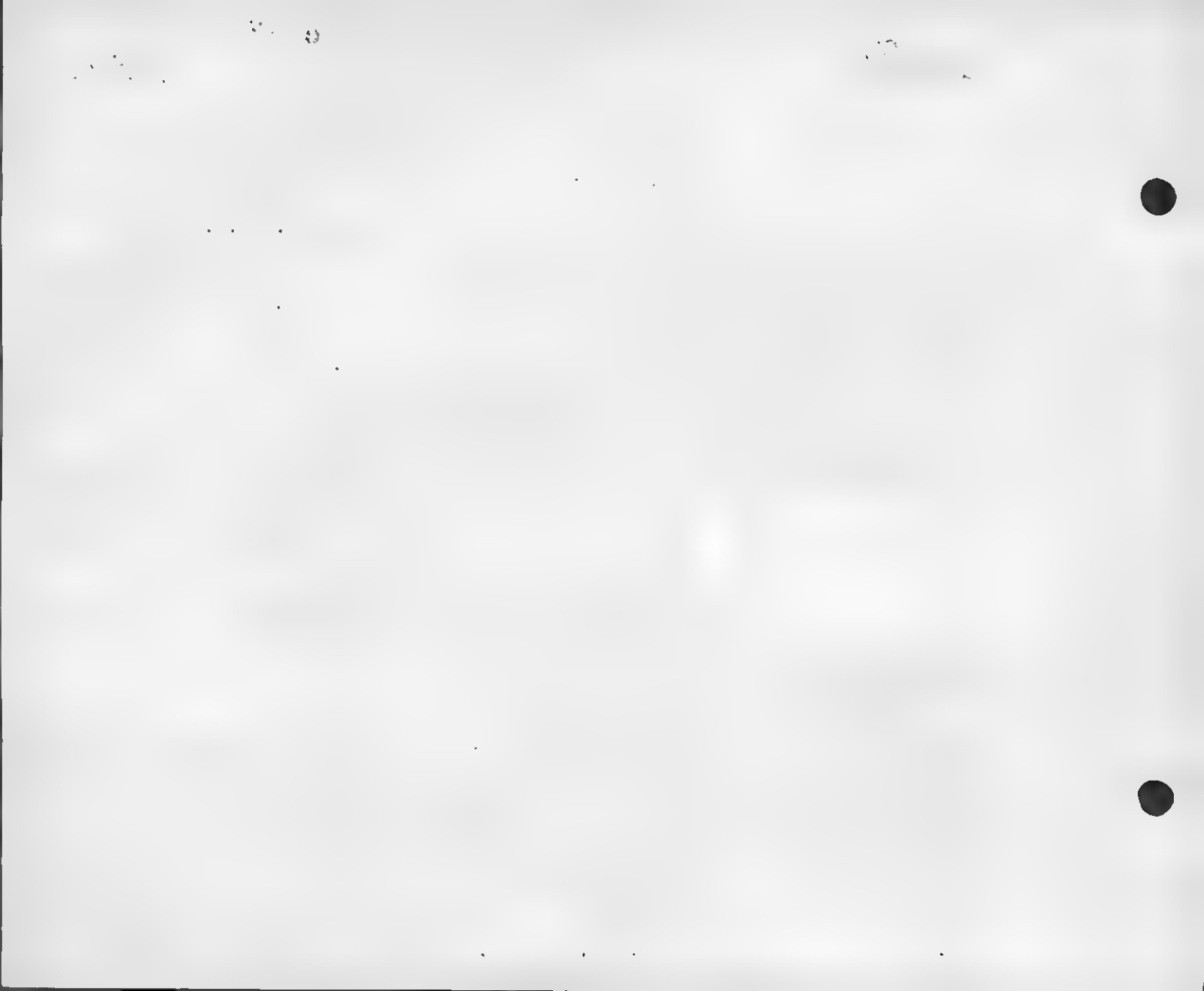
06813

CERTIFICATE OF DEATH

06806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN TB <u>1 Month - 5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> <u>901 Arcola Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>131 Jefferson St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Aloysius Bernard</u> First Middle Last			4. DATE OF DEATH <u>May 16 1967</u> Month Day Year				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1900</u>		9. AGE (In years) <u>67</u> yrs. (lost birthday)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yonkers, N.Y.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Yonkers, N.Y.</u>			
13. FATHER'S NAME <u>Stephen Bedmarchak</u>			14. MOTHER'S MAIDEN NAME <u>Anne Juhas</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>578-52-3902</u>		17. INFORMANT <u>Institutional records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>unmet</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>march 24 1967</u>, to <u>MAY 16 1967</u> that (I) (we) last saw the deceased alive on <u>may 16 1967</u>, and that death occurred at <u>6:30 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>William F Simpson</u> 22c. PHYSICIAN'S NAME (Type) <u>William F Simpson MD</u>				22b. DATE SIGNED 22d. ADDRESS <u>6216 N. H. Ave NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE THEREOF <u>5/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>	23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR <u>MAY 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. ...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06820

CERTIFICATE OF DEATH

06807

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 48 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		d. STREET ADDRESS 2828 Hurst Ter. NW.	
3 NAME OF DECEASED (Type or print) VERNON		4 DATE OF DEATH Month MAY Day 25 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-19-09
9 AGE, in years lost birthday 58 yrs		10 UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRIC CO		10b. KIND OF BUSINESS OR INDUSTRY Repair Co	
11 BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME VERNON A. BEST		14. MOTHER'S MAIDEN NAME HESTER EARP	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOC. A. SECURITY NO. 577-09-3351	
17 INFORMANT VERNON R. BEST		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction of right ventricle DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic lesion c. brain			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to May 25, 1967 that (I) (we) last saw the deceased alive on 5-24-1967 and that death occurred at 5:30 AM , from causes and on the date stated above			
22a. SIGNATURE Robert E. Brooker M.D.		22b. DATE SIGNED 5-25-67	
22c. PHYSICIAN'S NAME (Type) ROBERT E. BROOKER, M.D.		22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-29-67	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg Md
24 FUNERAL DIRECTOR L. H. CHAMBERS, Co		25a. RECEIVED BY REGISTRAR 3:12 P.M. 5/29/67	
25b. REGISTRAR'S SIGNATURE John J. Judge		DATE MAY 29 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed in a binder for use of a burial transcript, permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (11)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06821

06808

PLACE OF DEATH COUNTY <u>Montgomery</u> write RURAL and give nearest town) <u>Takoma Park</u>		MARYLAND LENGTH OF STAY IN MD <u>4 WKS</u>		USUAL RESIDENCE Where dec'd res'd before death STATE <u>Maryland</u> CITY OR TOWN <u>Takoma Park</u> write RURAL	
NAME OF HOSPITAL OR NURSING HOME (If not in hospital, give street address) <u>Washington Hunt Hospital</u>		STREET ADDRESS <u>116 Jackson Ave</u>		RESIDENT ON A FARM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
NAME OF DECEASED (Full name) <u>Clara Belle Binswanger</u>		DATE OF DEATH <u>5/27/67</u>		AGE <u>5</u> YEARS <u>07</u> MONTHS <u>19</u> DAYS	
SEX <u>Female</u>	RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH <u>9/12/62</u>	IF UNDER 1 YEAR Month <u>05</u> Day <u>27</u> Year <u>1967</u>	
OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		KIND OF BUSINESS OR INDUSTRY <u>& K/A.</u>		COUNTRY OF BIRTH <u>USA</u>	
FATHER'S NAME <u>William Thomas Hambro</u>			MOTHER'S MAIDEN NAME <u>Gertrude P. Hambro</u>		
WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or Unknown) (If yes give war or dates of service) <u>No</u>		SOCIAL SECURITY NO <u>77-32-0395</u>		INFORMANT <u>Hospital Chart</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <u>16-X</u> IMMEDIATE CAUSE (a) <u>16-X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS <u>None</u>					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature, location, Port I or Port II, or both)			
TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20c INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden K. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME (Type) <u>BELDEN K. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER	
24 FUNERAL DIRECTOR <u>Malley Funeral Home</u>		DATE THEREOF <u>5/31/67</u>		25a NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cem.</u>	
25b ADDRESS <u>3200 Red Oak Rd</u>		25c REC'D BY REGISTRAR <u>Colmer</u>		25d REGISTRAR'S SIGNATURE <u>Colmer</u>	
26 DATE <u>JUN 5 1967</u>		27			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

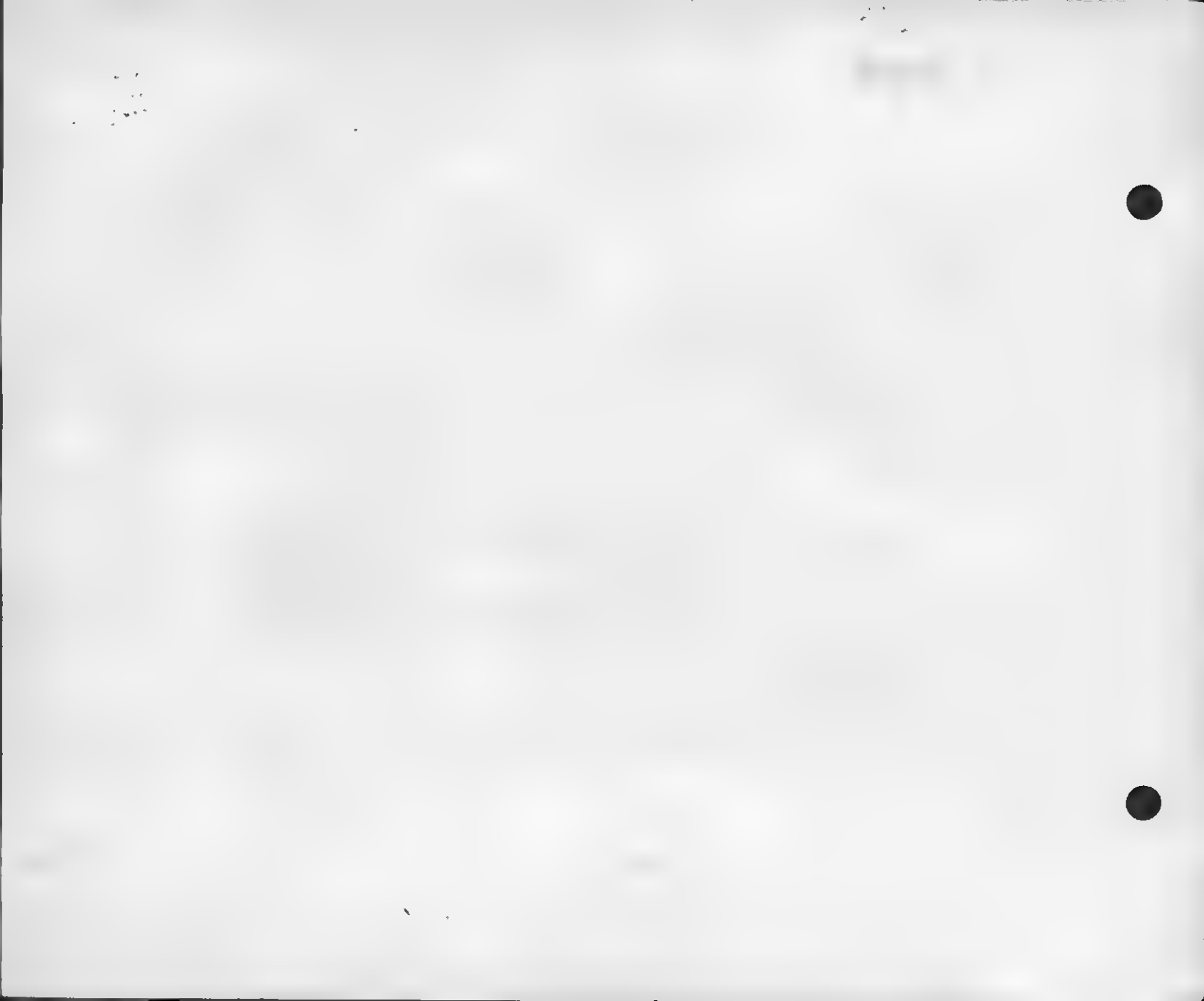
CERTIFICATE OF DEATH

06809

06822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		d STREET ADDRESS <u>1508 - Stratford 3rd</u>	
3 NAME OF DECEASED (Type or print) <u>John D. Birchhead</u>		DATE OF DEATH <u>MAY 9 1967</u>	
5 SEX <u>Male</u>	6 CO. OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/21/06</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>General Engineering</u>	11 BIRTHPLACE (County & State or foreign country) <u>Le. S. H.</u>
13 FATHER'S NAME <u>Harry Birchhead</u>		14 MOTHER'S MAIDEN NAME <u>MARY Campbell</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>577-07-8797</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> 4-22 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>1. - 1955 - 1960</u>		19 "WAS AUTOPSY PERFORMED?" YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>1967</u> , and that death occurred at <u>8:17</u> M from causes and on the date stated above			
22a SIGNATURE <u>John Wyman</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>John Wyman</u>		22d ADDRESS <u>7801 Hartford Ave. Beth. Md.</u>	
23a BURIAL, CREMATION, REINTERMENT (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>BURIAL</u>	<u>MAY 12, 1967</u>	<u>Cedar Hill Cem - Suitland</u>	<u>Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawlor's Sons, Inc. - Wash, D.C.</u>		25a REC'D BY REGISTRAR <u>MAY 17 1967</u>	25b REGISTRAR'S SIGNATURE <u>John D. Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06823

CERTIFICATE OF DEATH

06810

1 PLACE OF DEATH a COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c LENGTH OF STAY IN 1b <u>1 year</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>PORTZ, T. E.</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-2-1917</u>
9 AGE (In years last birthday) <u>49</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b KIND OF BUSINESS OR INDUSTRY <u>R. E. A.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>OHIO</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Russell Portz</u>		14 MOTHER'S MAIDEN NAME <u>Therestie Schmuck</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW II</u>		16 SOCIAL SECURITY NO <u>378-12-1010</u>	
17 INFORMANT <u>John G. Ball</u>		Address <u>Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and old</u> DUE TO (b) <u>Coronary arteriosclerosis with occlusion</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>24 April</u> , 19 <u>67</u> , to <u>date</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 May</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from causes and on the date stated above			
22a SIGNATURE <u>John G. Ball</u>		22b DATE SIGNED <u>5/15/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JOHN G. BALL</u>		22d ADDRESS <u>7936 Old Georgetown Rd Bethesda, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-17-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a MAY BY REGISTRAR <u>1967</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please repace coron papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Figure 1 consists of two scatter plots. The left plot shows a positive correlation between the number of children and the number of mothers, with a regression line indicating a positive slope. The right plot shows a negative correlation between the number of children and the number of mothers, with a regression line indicating a negative slope.

78

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06824

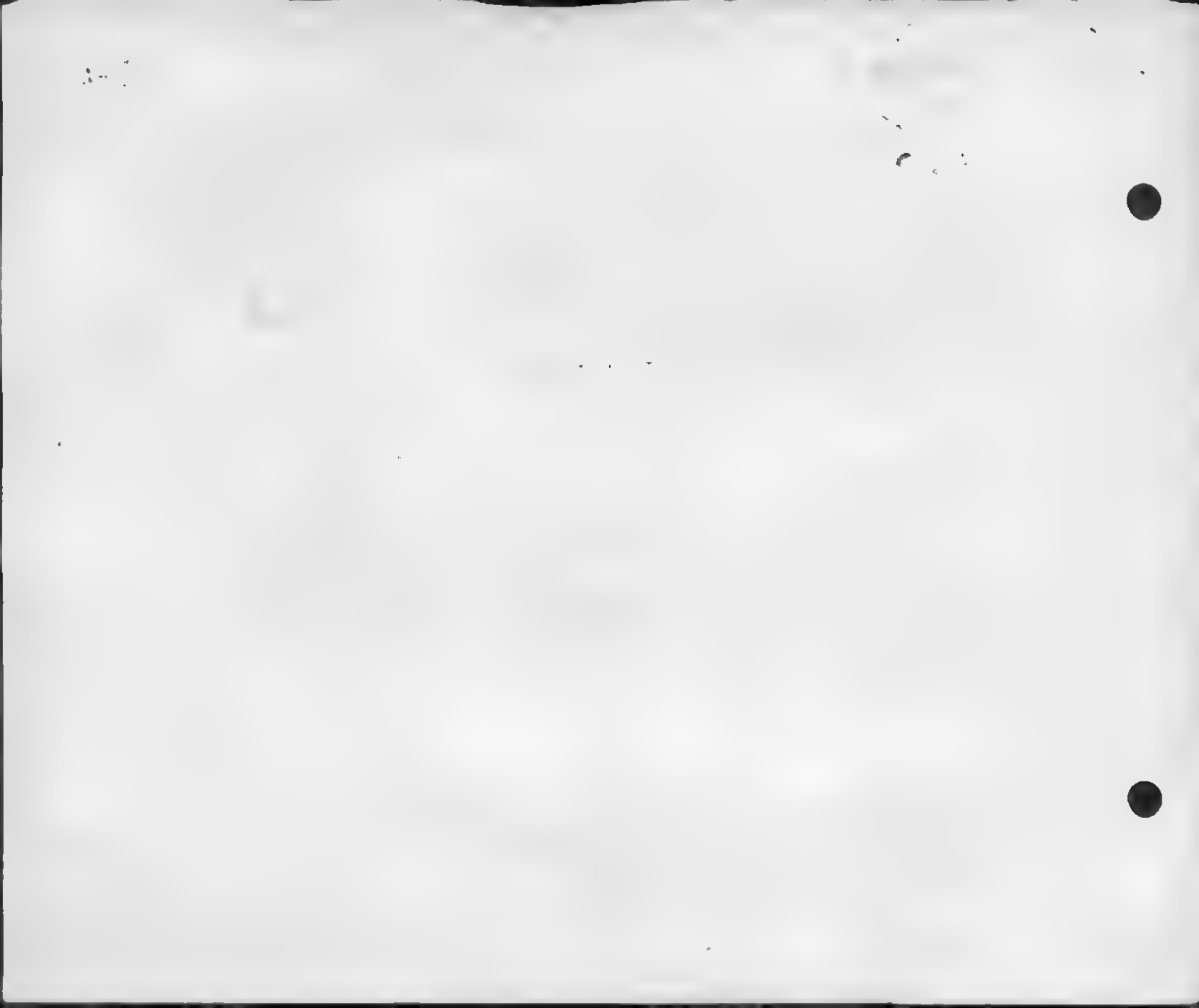
CERTIFICATE OF DEATH

06811

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) a. STATE <u>4733</u> b. COUNTY <u>Bradley BLUM.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<u>Res Mir SANITARIUM</u>		<u>5921 Grastetter LANE</u>	
3 NAME OF DECEASED (Type or print) <u>Norma U. BROWN</u>		4 DATE OF DEATH <u>MAY 6</u> 19 <u>67</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JULY 4, 1905</u>
9 AGE (In years last b. day) <u>61</u> yrs		10 UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (County & State or foreign try) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>FRANKLIN Underwood</u>		14 MOTHER'S MAIDEN NAME <u>Sarah R. Delaney</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>229-40-5659</u>	
17 INFORMANT <u>Hisband</u>		Address <u>Same as Itom. 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> F TO (b) <u>Myocardial Infarction - to lung</u> DUE TO (c) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3</u> hr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> (b) <u>Arteriosclerosis</u>		19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <u>May 6 1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, Farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>3-5</u> 19 <u>67</u> to <u>5-6</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-5</u> 19 <u>67</u> and that death occurred at <u>2P</u> M. from causes and on the date stated above			
22a SIGNATURE <u>William K. Kelly</u> M.D.		22b DATE SIGNED <u>5-11-67</u>	
22c PHYSICIAN'S NAME (Type) <u>William K. Kelly</u>		22d ADDRESS <u>8218 1st Avenue - Apt. 303</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>5-10-67</u>	<u>Riverview Cemetery</u>	<u>Richmond, Virginia</u>
24 FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>MAY 11 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and (any event, within 72 hours after death).



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06825

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

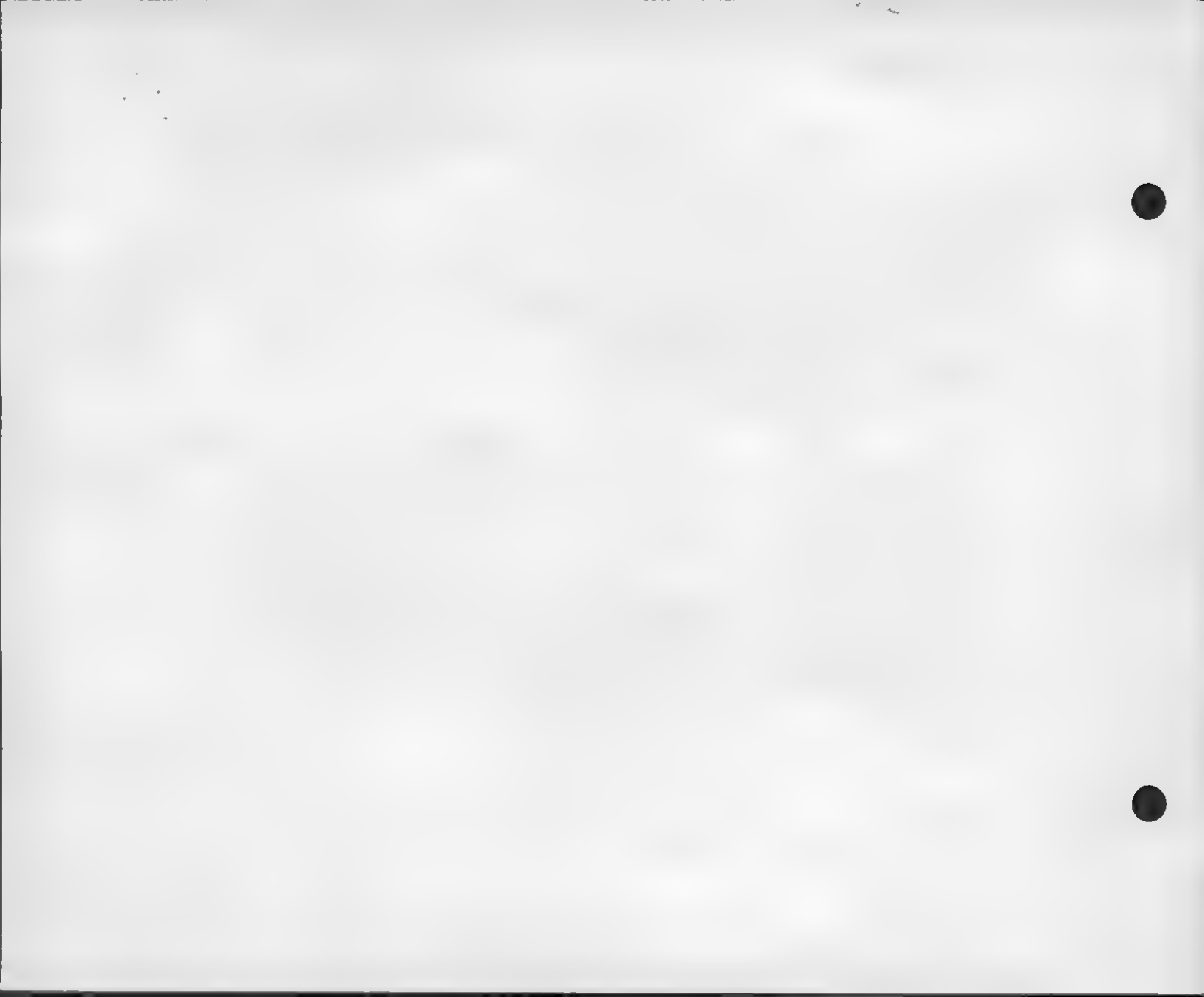
CERTIFICATE OF DEATH

06812

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (When deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN b <u>23 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium Hospital</u>		e STREET ADDRESS <u>10517 Lorain Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Georgiana Brown</u>		4 DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-31-73</u>
9 AGE (In years last birthday) <u>93</u> yrs		10 F UNDER 1 YEAR Months <u>0</u> Day <u>0</u> Hour <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Cum home</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William Keough</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-46-9358</u>	
17 INFORMANT <u>Lana A. Callahan</u> Address <u>10517 Lorain Ave. Md.</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED</u> DUE TO <u>OLD AGE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>OLD AGE.</u> DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Bank</u> 19 <u>47</u> to <u>May 28</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> P.M. from causes and on the date stated above			
22a SIGNATURE <u>Taken Callahan</u> M.D.		22b DATE SIGNED <u>May 28 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Frank G. Gorman, M.D.</u>		22d ADDRESS <u>1115 5th St. A.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>June 1, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24 FUNERAL DIRECTOR <u>Harriet E. Purphey, Inc.</u>		25a REC'D BY REGISTRAR <u>JUN 2 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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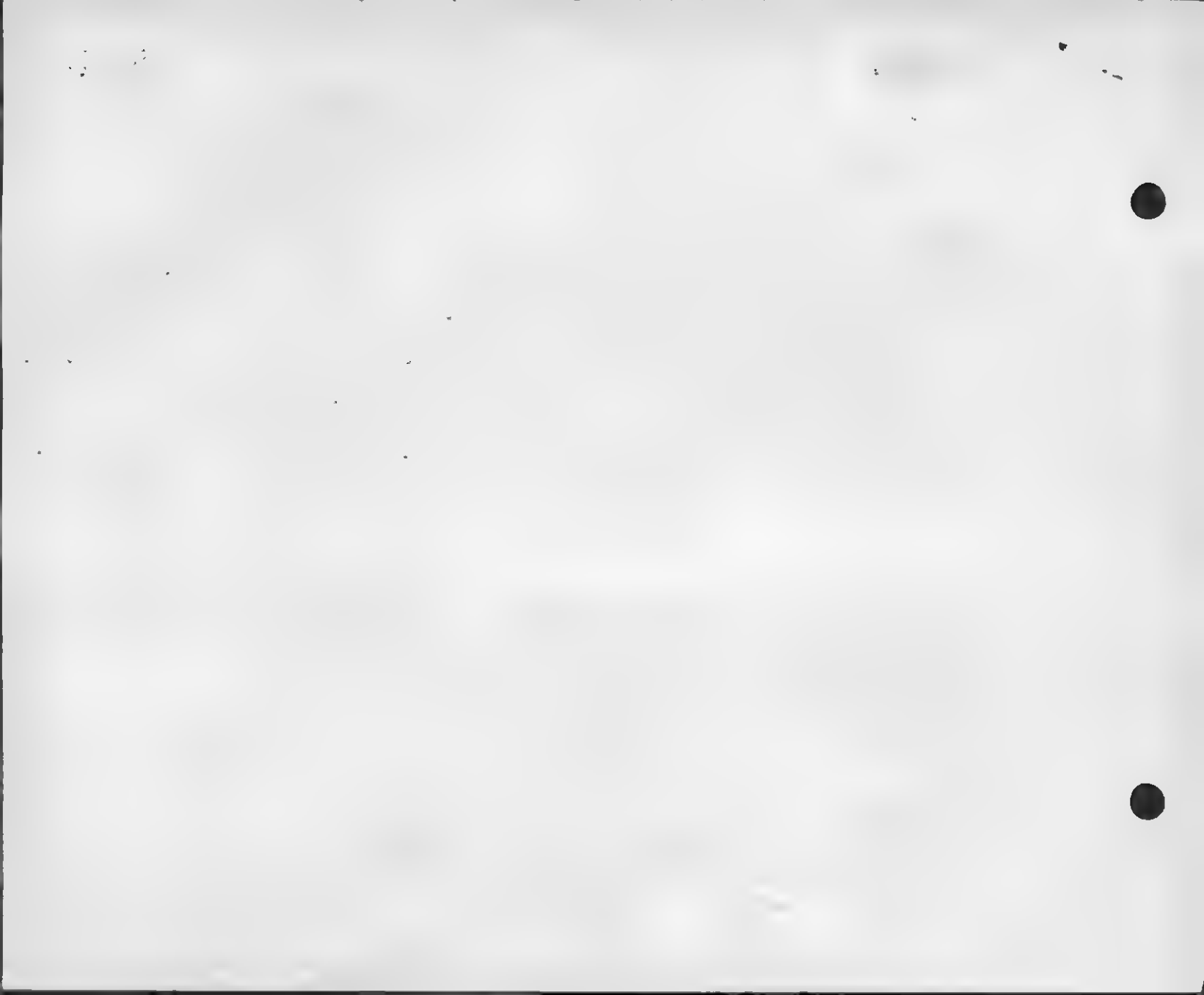
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06826

CERTIFICATE OF DEATH

06813

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
c. LENGTH OF STAY N 16 7 years		d. STREET ADDRESS 9618 Carriage Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9618 Carriage Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First VIVIAN Middle S. Last BROWN		4 DATE OF DEATH Month May Day 19 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 17, 1923
9 AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Penna.
12 CITIZEN OF WHAT COUNTRY? U. S.		13 FATHER'S NAME Michael Stroster	
14 MOTHER'S MAIDEN NAME Gladys M. Skelley		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO		17 INFORMANT Husband Address Howard C. Brown Same as item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of K tum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to (c) Due to			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 5/17/67 to 5/19/67 , that (I) (we) last saw the deceased alive on 5/17/67 19 67 , and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE ROBERT SCANLON		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT SCANLON		22d. ADDRESS	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5-22-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or town) (County) (State) Rockville, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. RECD BY REGISTRAR DATE MAY 24 1967	25b. REGISTRAR'S SIGNATURE Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06827

CERTIFICATE OF DEATH

06814

1 PLACE OF DEATH a COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) Frank T. Tamm		4 DATE OF DEATH Month Day Year 19 5 13 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-2-22
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country)
13 FATHER'S NAME Frank Tamm		14 MOTHER'S MAIDEN NAME Jane A. Murphy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	17 INFORMANT Silver Spring, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO CARCINOMA HEAD PANCREAS Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) JAUNDICE, OBSTRUCTIVE (c) INTERVAL BETWEEN DEATH AND FIRST			5-13-67 4-24-67 4-24-67
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (State)
21. I certify that (I) (this hospital) attended the deceased from April 24, 1967 to May 15, 1967 that (I) last saw the deceased alive on 5-14-1967, and that death occurred at 5:15 AM			
22a SIGNATURE George B. Patrick Jr. MD		22b DATE SIGNED 5-15-67	22c PHYSICIAN'S NAME (Type)
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR ADDRESS		25a REC'D BY REGISTRAR MAY 17 1967	25b REGISTRAR'S SIGNATURE Charles Judge

27

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is caused by the physician, the certificate should be forwarded to the Chief Medical Examiner's Office along with the body. 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health. It is not to be used for removal or in any event within 72 hours after death.

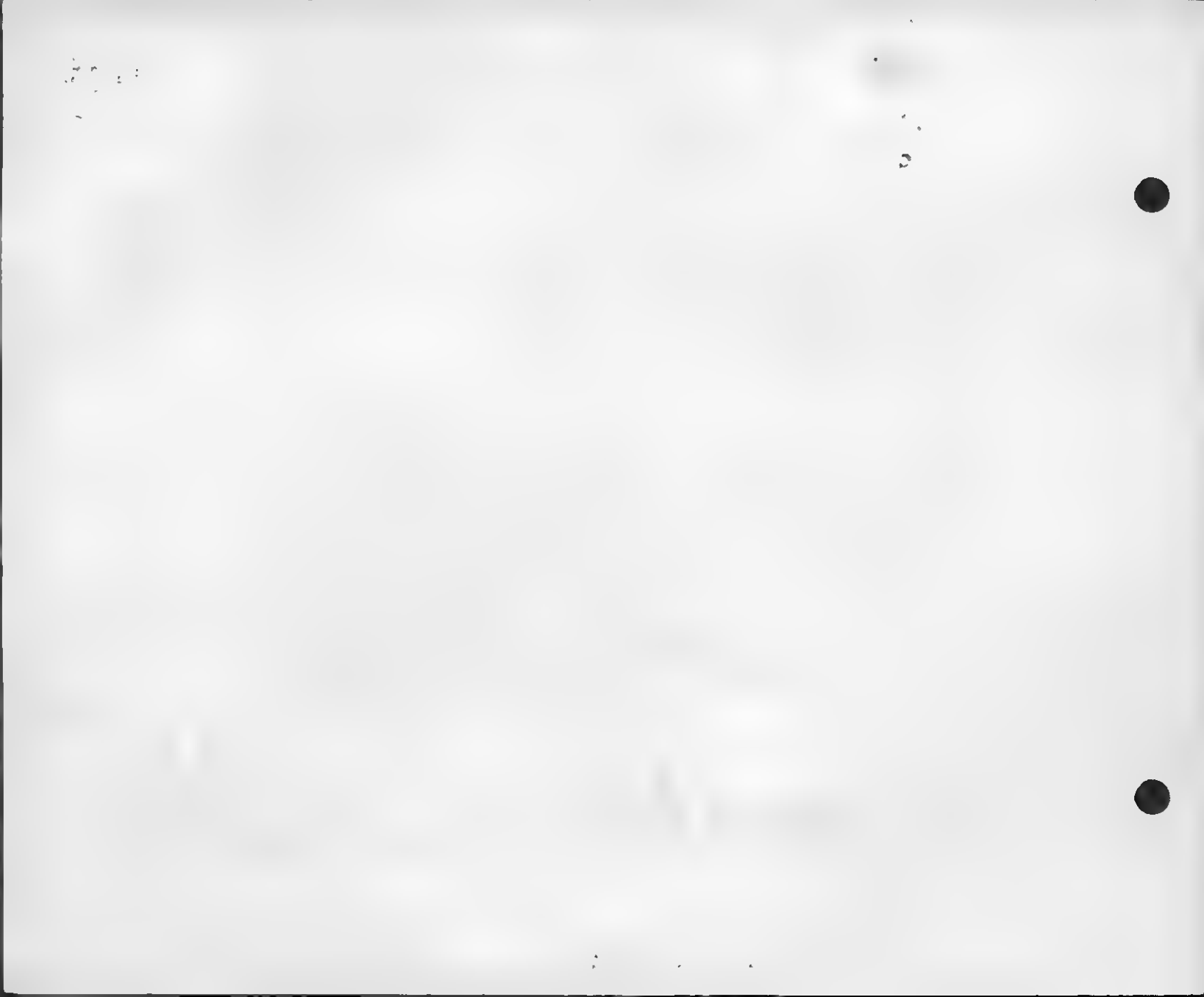
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06828

06815

PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		USUAL RESIDENCE STATE <u>MD</u>	
CITY OR TOWN <u>Bethesda</u>		CITY OR TOWN <u>Bethesda</u>	
NAME OF DECEASED <u>George Thomas Bumstead</u>		DATE OF DEATH <u>May 8 1967</u>	
SEX <u>Male</u>		DATE OF BIRTH <u>11/07/16</u>	
MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		BIRTHPLACE <u>USA</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTRY OF BIRTH <u>USA</u>	
FATHER'S NAME <u>Robert H. Bumstead</u>		MOTHER'S MAIDEN NAME <u>Ann Marie Swenson</u>	
CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		INTERVAL BETWEEN DEATH AND EXAMINATION	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DUE TO (b) <u>Coronary occlusion</u>			
DUE TO (c) <u>Coronary arteriosclerosis</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
I certify that the above information is true and correct.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John B. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/9/67</u>	
EXAMINER'S NAME		22 DATE SIGNED	
REMOVAL (Specify)			
Removal <u>5-11-1967 North Conway Cemetery, North Conway, New Hampshire</u>			
<u>Joseph Lawler's Sons, Inc.</u>		<u>MAY 17 1967</u>	
<u>5100 Wisconsin Ave. N.W., Wash. D.C.</u>		<u>John B. Ball</u>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1, 2, and 3 may be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A ME 6M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06829

06816

PLACE OF DEATH
a COUNTY

Montgomery

MARYLAND

2 USUAL RESIDENCE When reported
a STATE Conn.

b COUNTY Middlesex

c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

Silver Spring

d LENGTH OF STAY IN b

DOA

e CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

Deep River

f NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)

Holy Cross Hospital

g STREET ADDRESS

40 Spring Street

h IF DECEASED ON A FARM
YES ☐ NO ☒

NAME OF DECEASED
(Type or print)

Elmer

L.

Burr

4 DATE OF DEATH

Month May

Day 27 Year 19 67

SEX

M

6 COLOR OR RACE

W

7 MARRIED

☒ NEVER MARRIED ☐

8 DATE OF BIRTH

Nov. 10, 1895

9 AGE (last birthday)

71

10 FINDER'S YEAR MONTH DAY HOUR

11 OCCUPATION (Give kind of work done most of work up to even if retired)

Group leader

12b KIND OF BUSINESS OR INDUSTRY

Electrical Mfg.

13 BIRTHPLACE State or foreign country

Norwalk, Conn.

14 COUNTRY OF WHAT ENTRY

U.S.

13 FATHER'S NAME

Edwin Harrison Burr

14 MOTHER'S MARRIAGE NAME

Martha Canfield

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)

no

16 SOCIAL SECURITY NO

047-09-0662

17 INFORMANT

Christine Burr Same as #2

18a CAUSE OF DEATH (Enter only one cause per line for a, b, and c)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

Acute Coronary Insufficiency
Arteriosclerotic Heart Disease

18b RURAL DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

21 TIME OF INJURY Month Day Year
Hour a.m. 19
p.m.

22a INJURY OCCURRED While ☐ Not While ☐
of work at work

22b PLACE OF INJURY Home or factory, street, office bldg, etc.)

22c City

21 I certify that I took charge of the remains described above held on Autopsy ☐ Inspection ☒ Inquiry ☒
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME

BELDEN R. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED

5/27/1967

23a PLACE OF BURIAL

Burial

23b DATE THEREOF

5-31-67

23c NAME OF CEMETERY OR REPOSITORY

Fountain Hill Cemetery

23d CITY

Deep River, Connecticut

24 FUNERAL DIRECTOR

J. B. Thomas Warner E. Pumphrey, Inc. 8434 Georgia Ave.

25a DATE BY REGISTRAR

MAY 31 1967

25b REGISTRAR'S SIGNATURE

J. P. Jones Judge

100

4 2 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

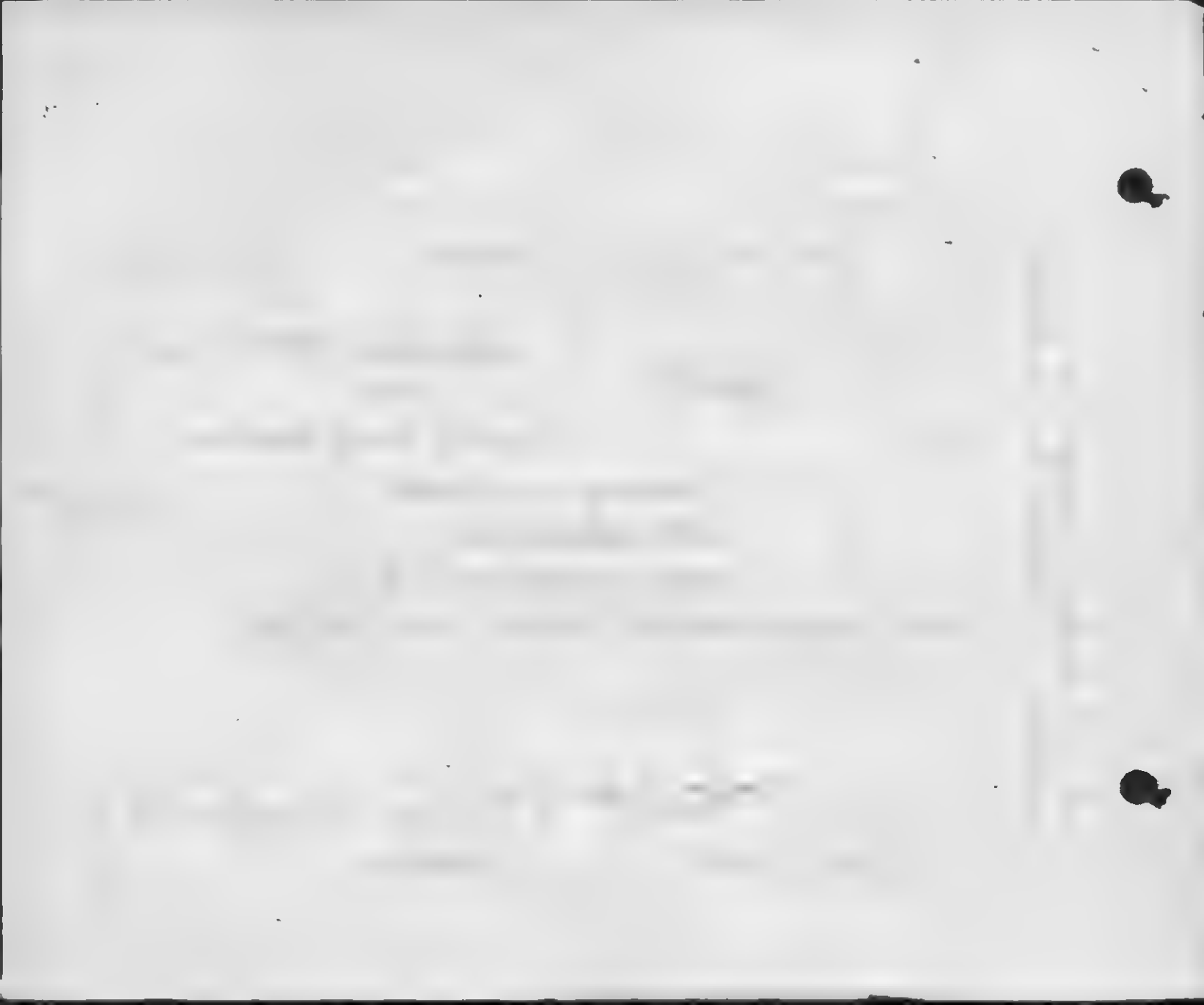
Reg. Dist. No. **06817**

06830

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8501 Hazelwood</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Caroline Martin Campbell</i>		4. DATE OF DEATH <i>May 27 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1890</i>
9. AGE (In years, last birthday) <i>76</i> yrs		10. IF UNDER 1 YEAR IF UNDER 1/4 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Missouri Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles E. Martin</i>		14. MOTHER'S MAIDEN NAME <i>Emma Entemman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>579-40-0030</i>	
17. INFORMANT <i>Daughter Dorothy Henderson</i>		Address <i>- Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) <i>Chronic congestive failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>Many Years</i> <i>6 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND CONDITION GIVEN IN PART I (a) <i>Recent cerebral vascular accident - two weeks ago.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 <i>63</i> to _____, 19 <i>63</i> , that I last saw the deceased alive on _____, 19 <i>63</i> , and that death occurred at <i>2 P.</i> M., from the causes and on the date stated above. <i>I had seen test 3 days ago & frequently before that.</i>			
ACTUAL SIGNATURE <i>Allen J. O'Neill</i>		ADDRESS (Street, city or town, state) <i>8601 Old Georgetown Rd</i> DATE SIGNED <i>5/27/67</i>	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		<i>Bethesda</i> <i>MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-30-67</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Darnestown, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>JUN 5 1967</i> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR TO FUNERAL DIRECTOR. The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Medical Examiner (Dr. Reape) & Dr. Stewart Clapp 4740 Chevy Chase Drive - usual doctor



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

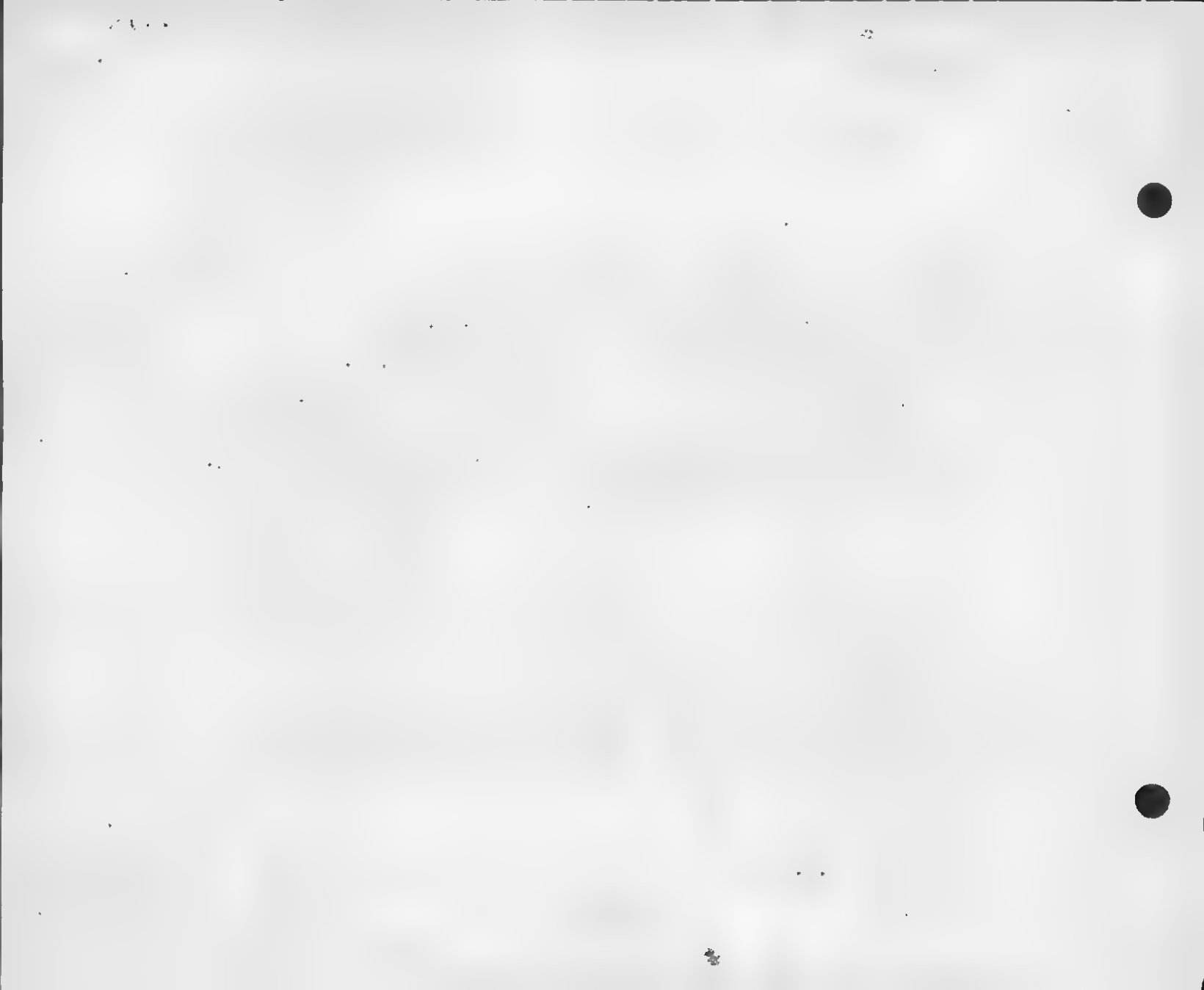
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06831

CERTIFICATE OF DEATH

06818

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Kentucky b COUNTY Varney	
b CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Bethesda(rural)		c LENGTH OF STAY IN 1b 67 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS PO Box 136	
3 NAME OF DECEASED (Type or print) First Charles Middle NMN Last Canada		4 DATE OF DEATH Month May Day 9 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 22, 1932
9 AGE (In years lost birthday) 34 yrs		10 IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min 34	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b KIND OF BUSINESS OR INDUSTRY Hatfield, Ky.	
11 BIRTHPLACE (County & State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Victor Canada		14. MOTHER'S MAIDEN NAME Sulia Cains	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes Active Duty		16. SOCIAL SECURITY NO. 234 48 2369	
17 INFORMANT Mr. Victor Canada		Address PO Box 136 General Del. Varney, Ky.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEIOMYOSARCOMA WITH WIDE SPREAD METASTASIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Mar. 3 , 19 67 , to May 9 , 19 67 , that (I) (we) last saw the deceased alive on May 9 , 19 67 , and that death occurred at 054A M. from causes and on the date stated above			
22a SIGNATURE R. N. Hood		22b DATE SIGNED May 9, 1967	
22c PHYSICIAN'S NAME (Type) R. N. HOOD MD		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 13, 1967	23c NAME OF CEMETERY OR CREMATORY Home Cemetery	23d LOCATION (City or town) (County) (State) Varney Ky.
24 FUNERAL DIRECTOR Rogers Funeral Home		25a REC'D BY REGISTRAR MAY 15 1967	
ADDRESS Belfry, Ky.		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

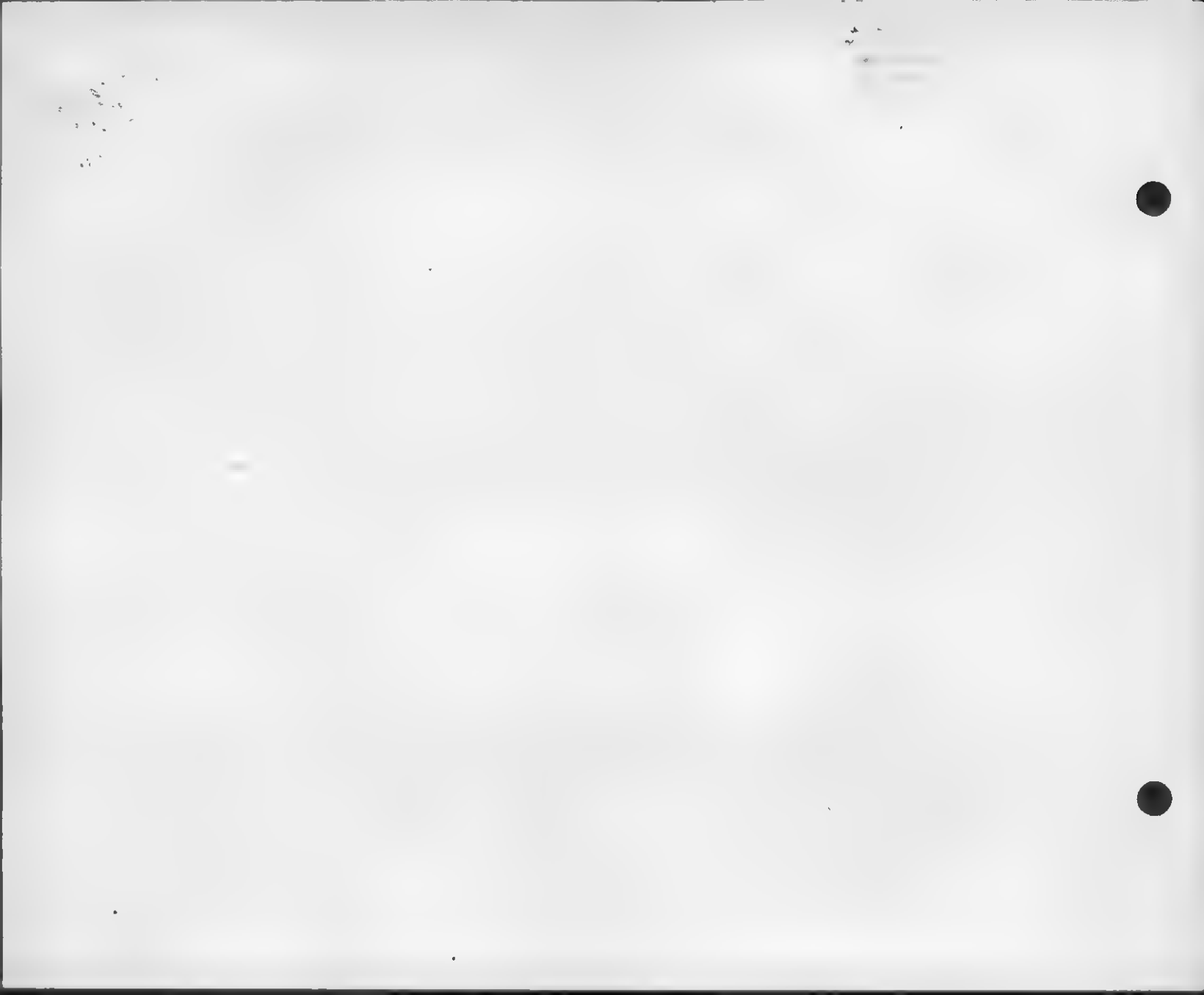
06832

Items #8 & 9 P17m #0

CERTIFICATE OF DEATH

06819

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>9 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>8410 New Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Edward</u> Last <u>Caulder</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	11. BIRTHPLACE (County if foreign country) <u>Marion Place South Carolina</u>
13. FATHER'S NAME <u>John C. Caulder</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Coats</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>247-16-4523</u>	17. INFORMANT <u>Evelyn Jacobs</u> Address <u>8410 N. H. Ave. Silver Spring, MD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Urinary tract infection</u> DUE TO (c) <u>Carcinoma of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/15, 1967</u> to <u>5/13, 1967</u> that (I) (we) last saw the deceased alive on <u>5/13, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.		22b. DATED SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN H. RUBENSTEIN</u>		22d. ADDRESS <u>11161 New Hampshire Ave. S.L. Sp. MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McColl Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bennettsville, S.C.</u>
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home</u>		25. REC'D BY REGISTRAR <u>MAY 22 1967</u>	
ADDRESS <u>Alex., Va.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

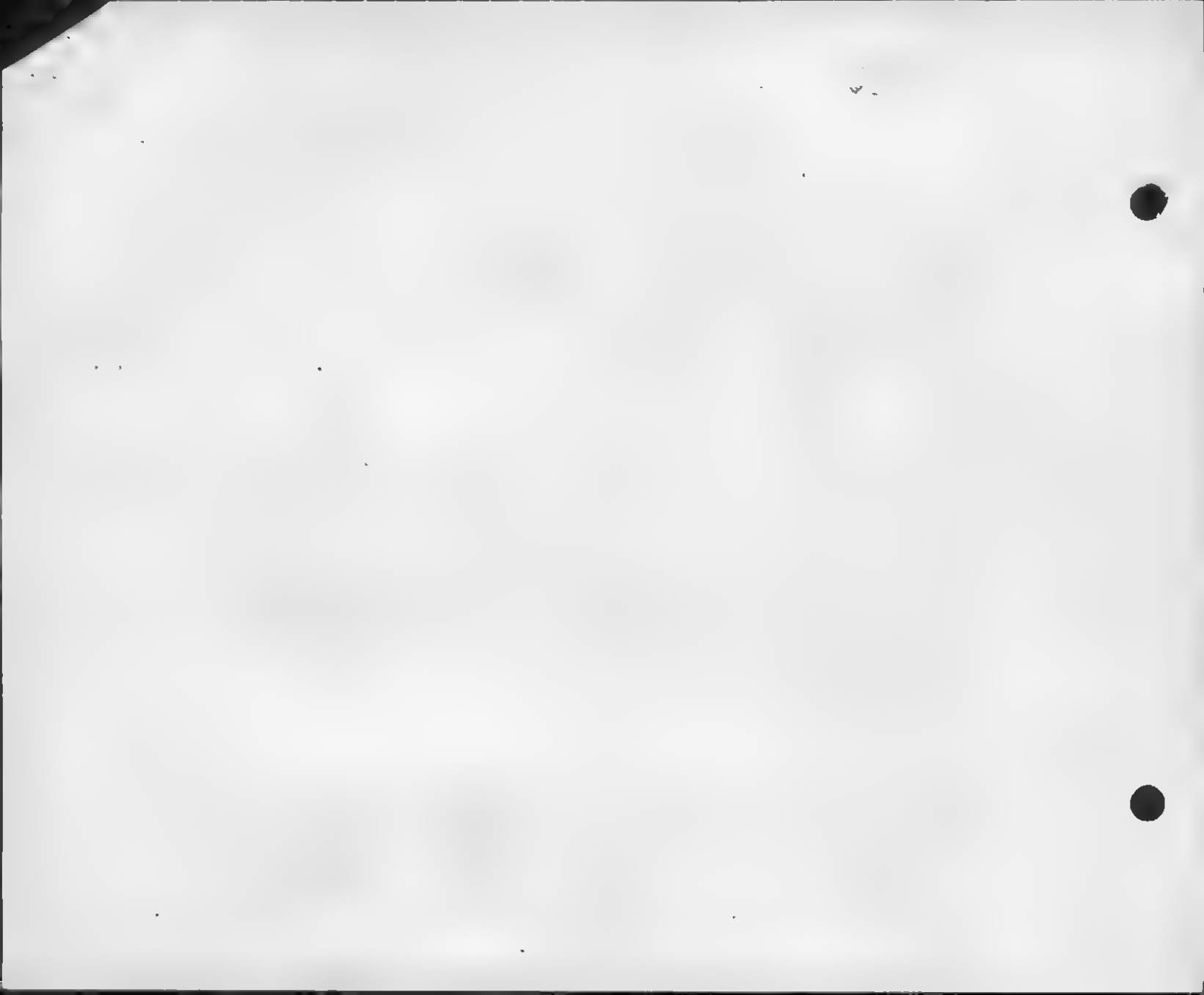
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06833

CERTIFICATE OF DEATH

06820

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTG.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			c. LENGTH OF STAY IN TB YRS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE #3 BOX 207			d. STREET ADDRESS ROUTE #3 BOX 207		
3 NAME OF DECEASED (Type or print) First Middle Last BERTHA LENORA CHAMBERS			4 DATE OF DEATH Month Day Year MAY 22 19 67		
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 15, 1886		9 AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11 BIRTHPLACE (County & State or foreign country) STAUNTON, VA.		12 COUNTRY OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN			14 MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17 INFORMANT Address MR WILLIAM E. CHAMBERS (SAME AS ABOVE)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Transition -</u> DUE TO <u>chronic drainage</u> (and trans if any, which gave rise to immediate cause (a), stating the underlying cause last) DUE TO (b) <u>Diarrhea</u> (c) <u>colitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>7 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Family - refusal to eat</u>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27, 19 58</u> to <u>5/22, 19 67</u> that (I) (we) last saw the deceased alive on <u>4/27, 19 67</u> , and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Stephen W. Jones</u> M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>5/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen W. Jones</u>		22d. ADDRESS <u>Baltimore, Md</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 25, 1967	23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEMETERY		23d. LOCATION (City or town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS ROCKVILLE, MD.		25a. RECD BY REGISTRAR MAY 24 1967	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

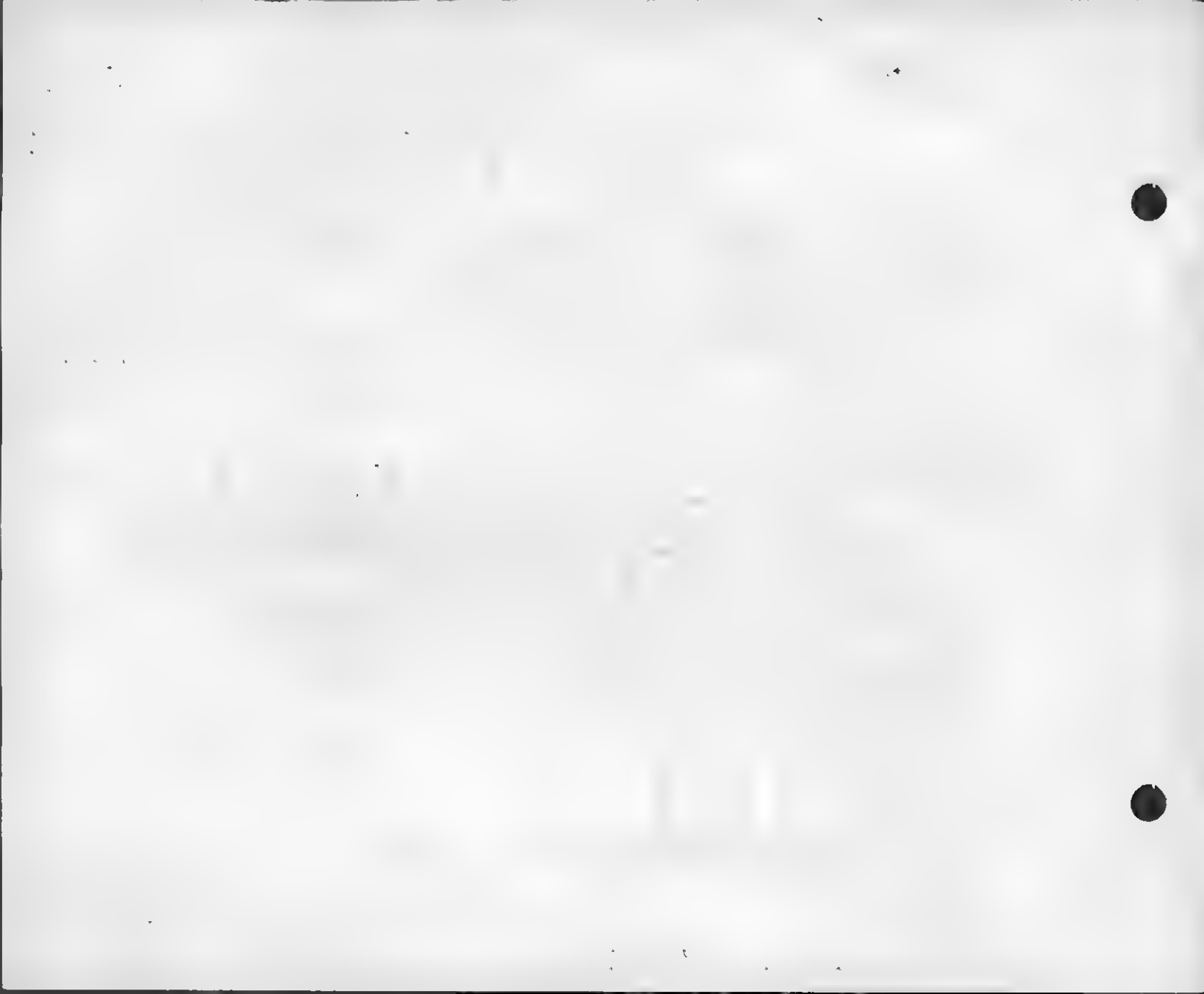
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06834

06821

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b 3 mos. 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Dist. of Col. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5709 Colorado Ave. N.W. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar F. Chandler		4. DATE OF DEATH Month May Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1887
9. AGE (in years last birthday) 80 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (County & State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Chandler	
14. MOTHER'S MAIDEN NAME Melvina Vigar		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1917-1919	
16. SOCIAL SECURITY NO. 579-60-0840		17. INFORMANT Russell T. Andrews-See Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO Cerebral arteriosclerosis (b) (Previous attack of) Cerebral thrombosis DUE TO with Hemiplegia (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-22 , 19 55 to May 6 , 19 67 , that (I) (we) last saw the deceased alive on April 18 , 19 67 , and that death occurred at 1 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Aaron Nimetz		22b. DATE SIGNED 5-6-67	
22c. PHYSICIAN'S NAME (Type) AARON NIMETZ		22d. ADDRESS 5501-16 St. N.W. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-10-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Joseph Fowler's Sons, Inc. 1130 Wisconsin Ave. N.W. Wash. D.C.		25. MAY 10 1967 REGISTRAR'S SIGNATURE James	



06835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06822

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town) Lakema Park		c. LENGTH OF STAY IN 1b 36 hours		2 USUAL RESIDENCE (Where deceased lived 1 month or more before death) a. STATE Maryland b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS 309 Bond Mill Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Lenora Mae Childers		4 DATE OF DEATH May 1 1967		5 SEX Female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 8-10-34		9 AGE (In year, month, day) 32 yrs	
10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress-housewife		11b. KIND OF BUSINESS OR INDUSTRY Hot Shoppes		11. BIRTHPLACE (State or foreign country) West Virginia		12. COUNTRY OF WHAT COUNTRY? America		13 FATHER'S NAME Woodrow Wilson		14 MOTHER'S MAIDEN NAME Juanita Neff			
15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		7 INFORMANT Patient's chart		Address							
18 CAUSE OF DEATH (Enter on any one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) and (c)) Multiple extreme injuries with internal hemorrhage		19 INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18)											
21. I certify that I took charge of the remains described above and an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED May 1, 1967											
23a. BURIAL CREMATION (Specify) BURIAL		23b. DATE THEREOF 5/4/1967		23c. NAME OF CEMETERY OR CREMATORY CLINTONVILLE, W. VA.		23d. LOCATION (City or Town) (County) (State) CLINTONVILLE, W. VA.		24 FUNERAL DIRECTOR William M. Hysong		25a. REC'D BY REGISTRAR MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

(M)

06836

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06823

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Health Department. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN <u>Takoma Park</u> c NAME OF HOSPITAL OR INSTITUTION <u>Washington San. & Hospital</u>		2 LENGTH OF STAY IN <u>9 Hours</u>		3 USUAL RESIDENCE a STATE <u>Maryland</u> b CITY OR TOWN <u>Huattsville</u> c STREET ADDRESS <u>1969 Erie St Apt 104</u>	
4 NAME OF DECEASED (Type or print) <u>Casper John Chirieleison</u>		5 DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>		6 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7 SEX <u>M</u>	8 COLOR OR RACE <u>W</u>	9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 DATE OF BIRTH <u>July 31, 1911</u>	11 AGE (In years last birthday) <u>55</u>	12 IF DECEASED IN A FOREIGN COUNTRY, GIVE COUNTRY <u>U.S.A.</u>
13 USUAL OCCUPATION (Give kind of work done, occupation, or profession, even if retired) <u>Auto Mechanic Co-op Consumers</u>		14 KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		15 BIRTHPLACE (State, foreign country, or country) <u>U.S.A.</u>	
16 FATHER'S NAME <u>JOSEPH CHIRIELEISON</u>		17 MOTHER'S MAIDEN NAME <u>GIOVANNA BRIGUGLIO</u>		18 WAS DECEASED EVER IN ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes, give year or dates of service) <u>1941-1945</u>	
19 SOCIAL SECURITY NO. <u>578-05-3530</u>		20 INFORMANT <u>Wife</u>		21 ADDRESS <u>Same</u>	
22 PART I CAUSE OF DEATH (Enter one cause per line for (a) and (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Coronary Artery Heart Disease</u> CONDITIONS (b) WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (c)		23 INTERVAL BETWEEN ONSET AND DEATH		24 PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NATURE OF DEATH (Enter in Part I or Part II of item 18)					
26a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		26b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
27a TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		27b INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		27c PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.)	
27d (City or town)		27e (County)		27f (State)	
28 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Other <input type="checkbox"/>					
29 ACTUAL SIGNATURE <u>Belden R. Keap</u>		30 CHIEF MEDICAL EXAMINER <u>Belden R. Keap M.D.</u>		31 ASSISTANT MEDICAL EXAMINER <u>Wheaton</u>	
32 EXAMINER'S NAME (Type) <u>BELDEN R. KEAP</u>		33 NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		34 DATE SIGNED <u>5/21/1967</u>	
35 FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u>		36 DATE THEREOF <u>24 MAY 1967</u>		37 BALTIMORE MD.	
38 JUDGE <u>WASHINGTON, DC 20012</u>		39 MAY 23 1967		40	



TO DEPUTY MEDICAL EXAMINER: If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office ~~at~~ 1:30 PM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: If the person is buried, transcribe and file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

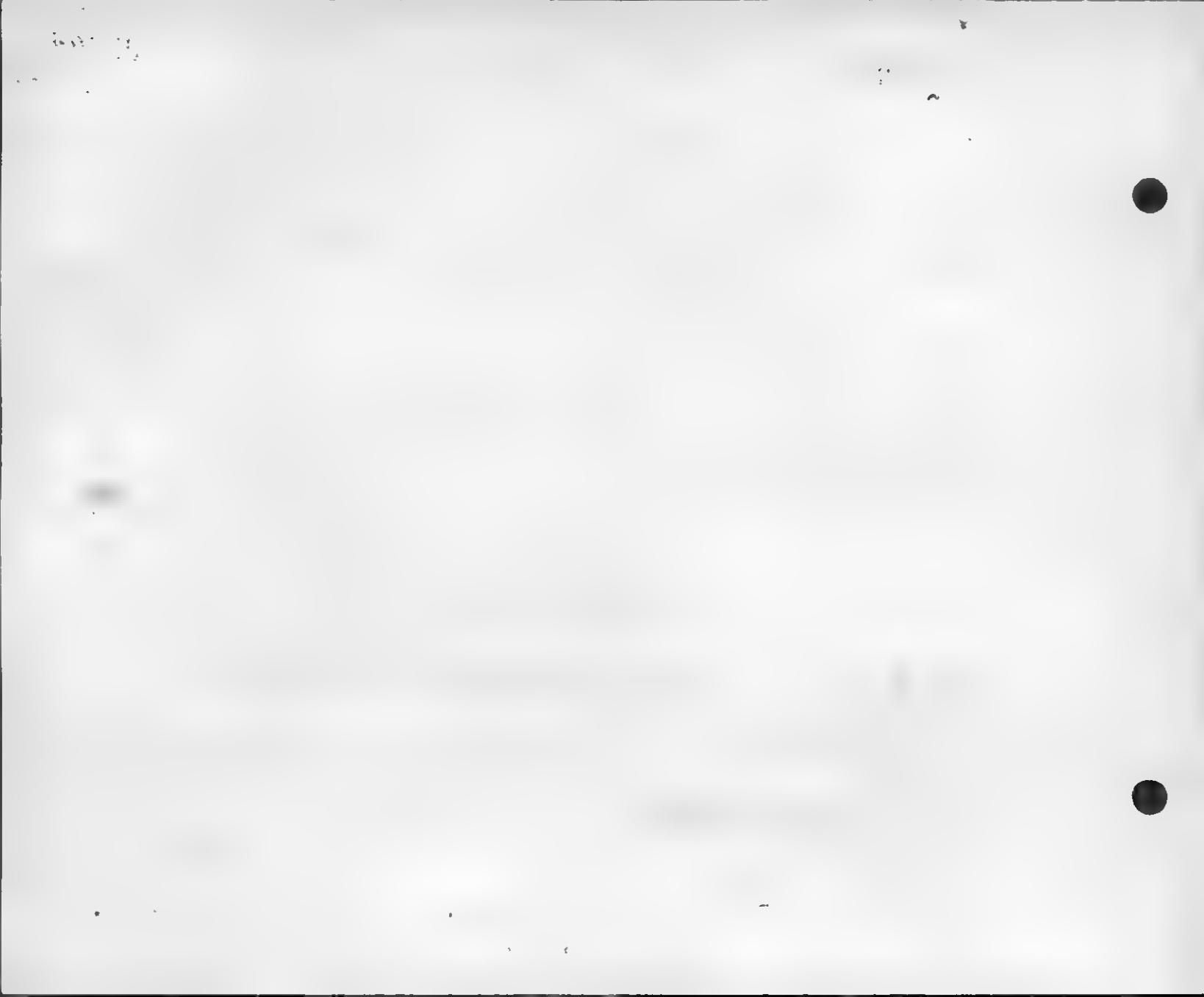
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06837

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06824

[illegible]



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06838

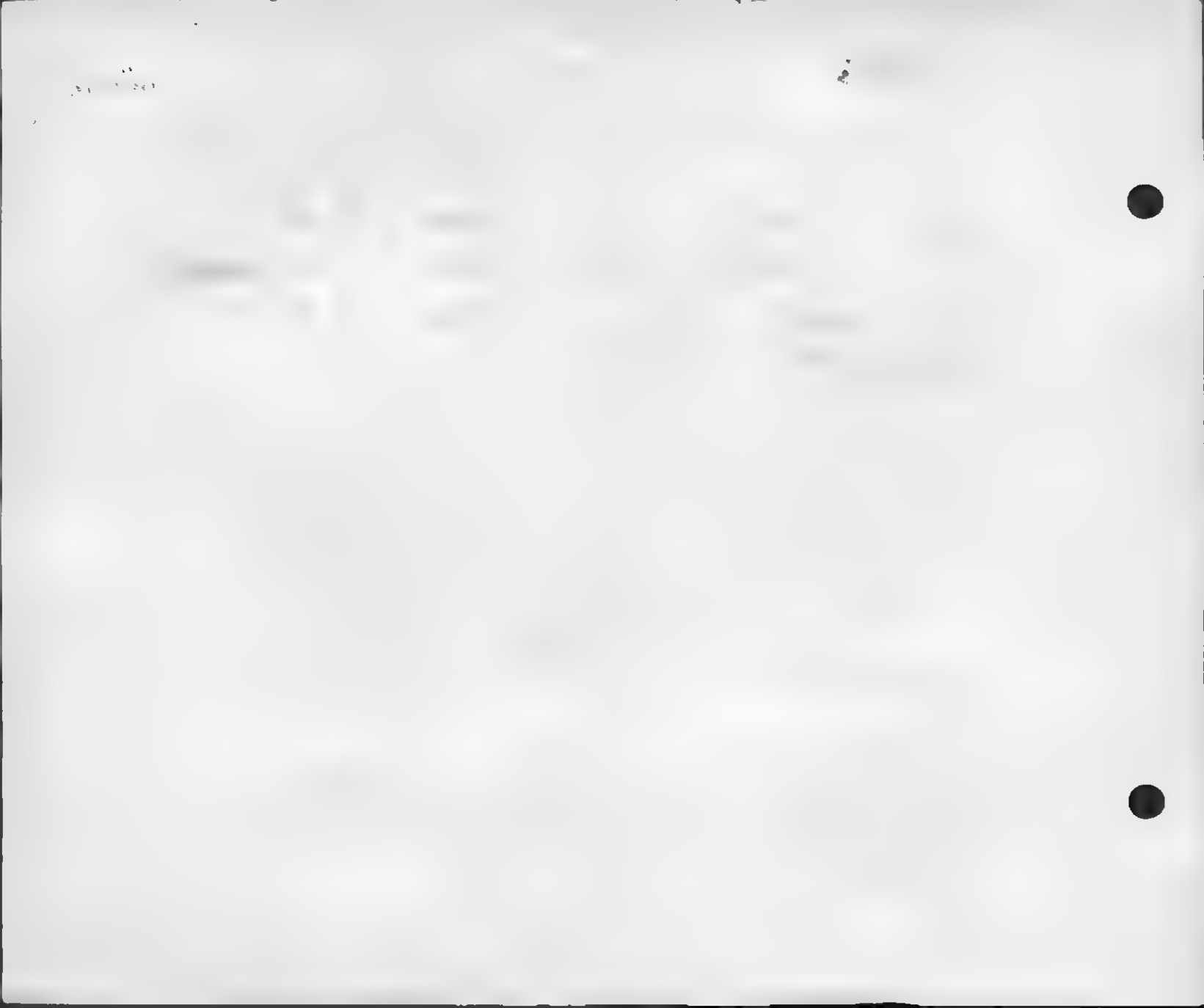
CERTIFICATE OF DEATH

06825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if not state of residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN ID <u>10 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d STREET ADDRESS <u>8408 10th AVE</u>			
3 NAME OF DECEASED (Type or print) <u>Cleveland Paul</u> First Middle Last				4 DATE OF DEATH <u>May 2</u> 19 <u>67</u> Month Day Year			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/16/11</u>		9 AGE (If years, last birthday) <u>55</u> yrs		10 UNDER 24 HRS Months Days Hours Mins
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Vitro Lab.</u>		11 BIRTHPLACE (County & State or foreign country) <u>Illinois</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Robert L. Conter</u>				14 MOTHER'S MAIDEN NAME <u>Frances Conter</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>571-03-7435</u>		17 INFORMANT <u>8408 10th Ave., Silver Spring, Md.</u> Address			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> <u>443 X</u> DUE TO (b) <u>Myocardial infarction</u> Contributions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Coronary atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute myocardial infarction</u> (b) <u>Myocardial infarction</u> (c) <u>Myocardial infarction</u>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>7/16/5</u> 19 <u>65</u> to <u>THE PRESENT</u> that (1) (me) last saw the deceased alive on <u>1967</u> 19 <u>67</u> , and that death occurred on <u>5/2/67</u> from causes and on the date stated above							
22a SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b DATE SIGNED <u>May 2, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>CLEVELAND PAUL</u>				22d ADDRESS <u>8408 10th Ave., Silver Spring, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>May 6, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>	
24 FUNERAL DIRECTOR <u>Warner E. P. ...</u> ADDRESS <u>8434 Georgia Avenue</u>				25a REC'D BY REGISTRAR <u>May 5 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06833

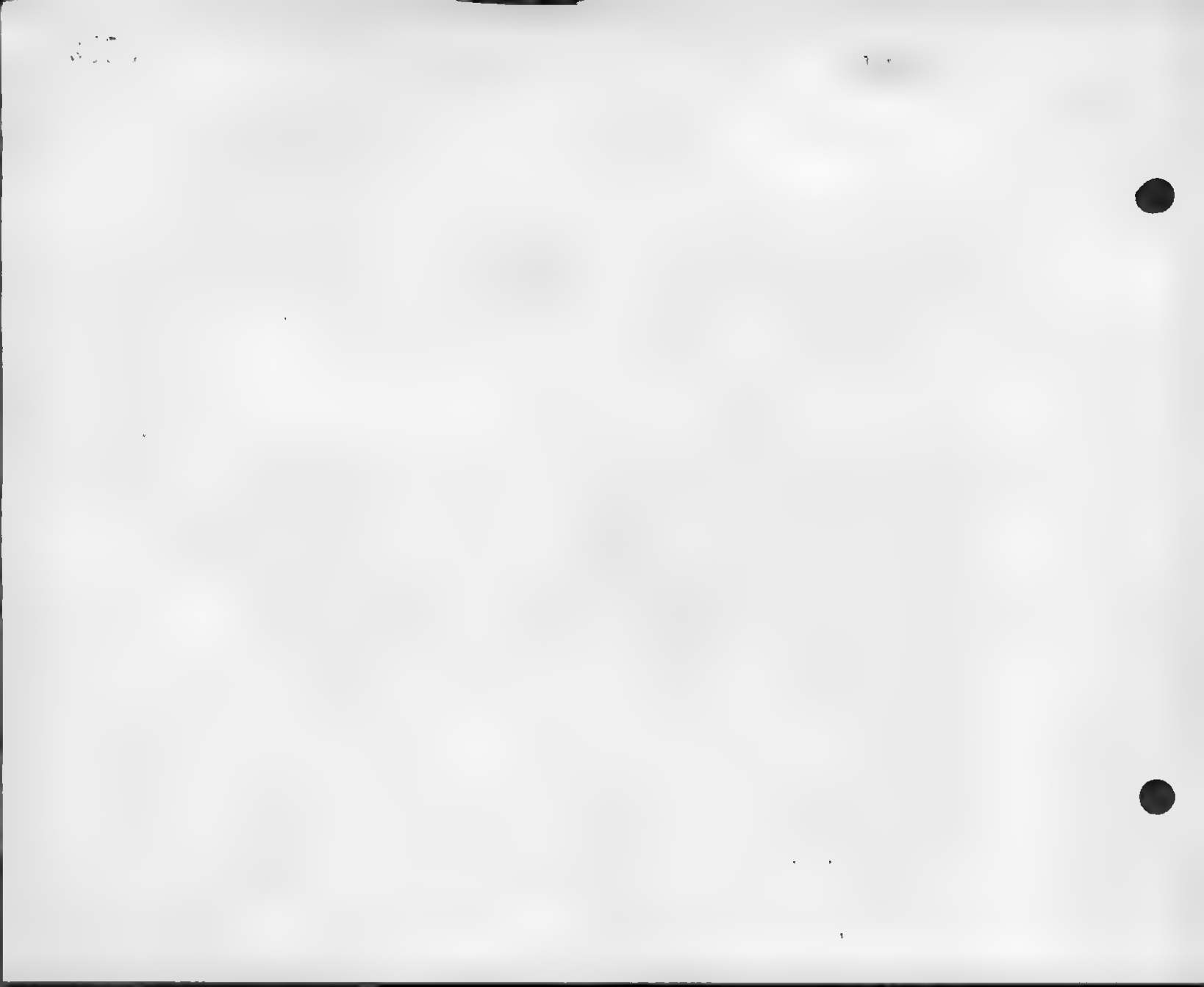
CERTIFICATE OF DEATH

06826

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. lnt on Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN b 116 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address) Naval Hospital		e STREET ADDRESS 113 Spaview Avenue	
3 NAME OF DECEASED (Type or print) James Ambrose COGHLAN		4 DATE OF DEATH May 14, 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 5, 1893
9 AGE 'In years last birthday' yrs 74		10 IF UNDER 1 YEAR Months Days Hours Min	
11a SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		11b KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (County & State or foreign country) Pennsylvania		13 CITIZEN OF WHAT COUNTRY? USA	
14 FATHER'S NAME John Joseph Coghlan		15 MOTHER'S MAIDEN NAME Mary Agnes	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes 1911-1942		17 SOC. A. SECURITY NO. 220-44-1033	
18 INFORMANT Mrs. Catherine H. Coghlan, 113 Spaview Ave. Annapolis Md.		19 ADDRESS Md.	
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia; Hypertensive cardiovascular disease			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
22a TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22b INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23a PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23b (City or town) (County) (State)	
24 I certify that (1) (this hospital) attended the deceased from Jan. 18, 1967 , to May 14, 1967 , that (1)(we) last saw the deceased alive on May 14, 1967 , and that death occurred at 8:20 PM , from causes and on the date stated above.			
25a SIGNATURE <i>R. J. Kinney</i>		25b DATE SIGNED May 15, 1967	
26a PHYSICIAN'S NAME (Type) R. J. Kinney, M.D.		26b ADDRESS Naval Hospital, Bethesda, Md.	
27a BURIAL CREMATION REMOVAL (Specify) Burial		27b DATE THEREOF 5/18/67	
27c NAME OF CEMETERY OR CREMATORY Arlington National		27d LOCATION (City or Town) (County) (State) Arlington, Va.	
28 FUNERAL DIRECTOR Hopping Funeral Home		28a ADDRESS Annapolis, Maryland	
29 REC'D BY REGISTRAR MAY 19 1967		29a REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

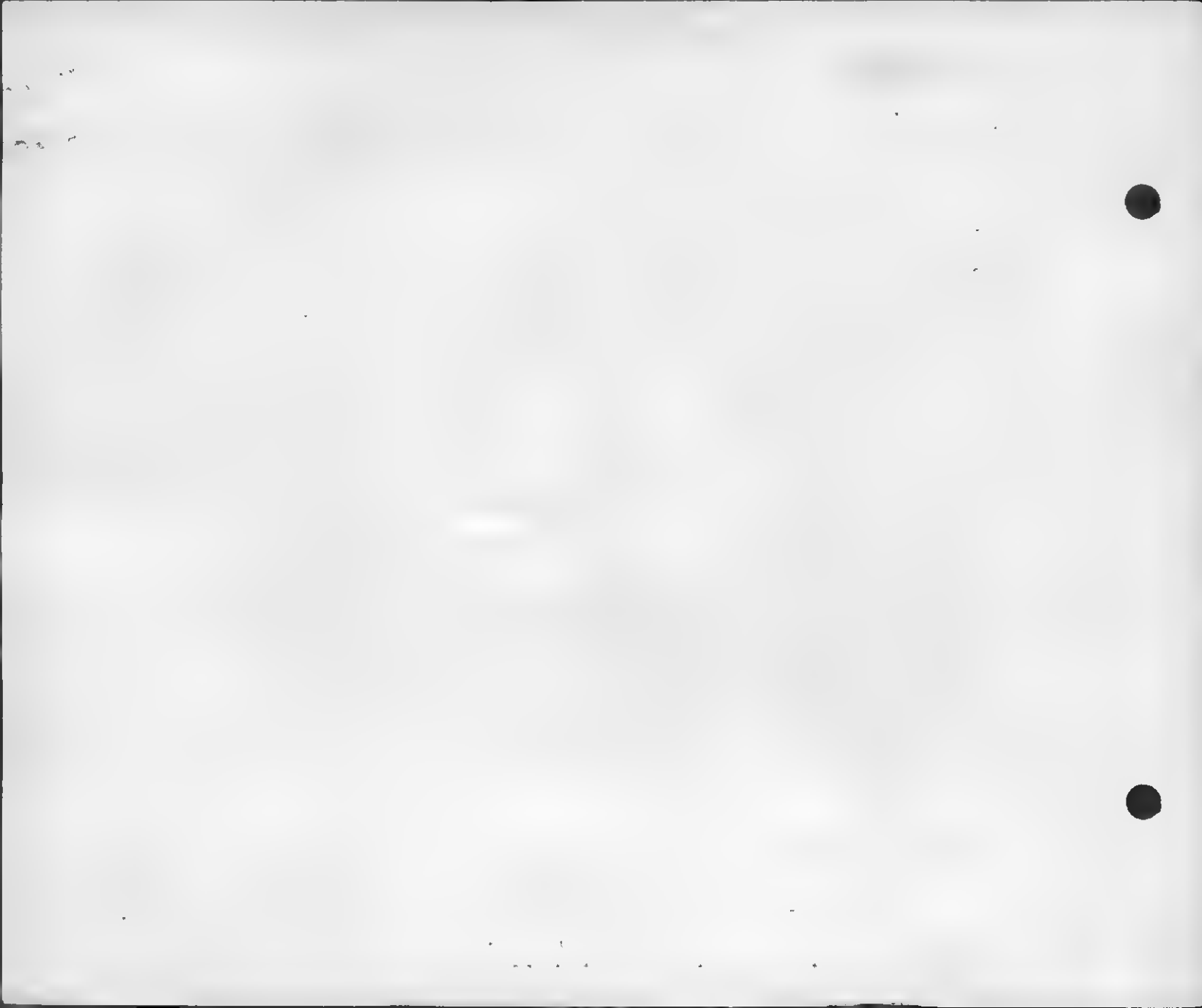
06827

06840

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not in on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>10612 BLUEBANK DR</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATILDA DOOSE COLUMAN</u>		4. DATE OF DEATH Month Day Year <u>MAY 15 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-17 49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert James</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Doose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Thelma Doose</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Cerebral Edema</u> DUE TO (c) <u>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4 mo</u> <u>6 mo</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAAL IF Y PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 1950 to <u>5/14</u> 1967 that (I) (we) last saw the deceased alive on <u>5/14</u> 1967, and that death occurred at <u>3A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Frank Y Jaggers Jr</u> M.D.		22b. DATE SIGNED <u>5/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK Y JAGGERS JR.</u>		22d. ADDRESS <u>5707 WISCONSIN AVE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>5-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Methodist Church / Potomac, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gailer's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>5130 Misc. Ave. N.W. Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 22 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06841

CERTIFICATE OF DEATH

06828

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE <u>md.</u> b COUNTY <u>Mont</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 16 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e STREET ADDRESS <u>2225 Washington Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Robert Collins</u>		4 DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/2/35</u>
9 AGE (In years, day, month, year) <u>31</u> yrs		10 UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
13 BIRTH PLACE (County & State or foreign country) <u>Pennsylvania</u>		14 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15 FATHER'S NAME <u>John Collins</u>		16 MOTHER'S MAIDEN NAME <u>Mary C'Brien</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18 SOC. SEC. NO. <u>712-14-4783</u>	
19 INFORMANT <u>Wife - Catherine</u>		Address <u>2225 Washington Ave.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal obstruction, small bowel</u> DUE TO (b) <u>Primary gastric adenocarcinoma</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>1 year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb 19, 1958</u> to <u>May 11, 1967</u> that (I) (we) last saw the deceased alive on <u>May 11, 1967</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Allen J. O'Neill</u>		22b DATE SIGNED <u>May 11, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill, MD</u>		22d ADDRESS <u>8601 Old George Town Rd, Bethesda Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>May 15, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24 FUNERAL DIRECTOR <u>St. Agnes Cemetery</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 15 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06829

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND

c. LENGTH OF STAY IN town

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence town or institution)

a. STATE

Maryland

b. COUNTY

Montgomery

Bethesda

d. STREET ADDRESS

5801 Massachusetts Ave. N.W.

b. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

BESSIE

LOUISE

COCKSEY

4. DATE OF DEATH

May

Day

3

Year

1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-24-1883

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Maryland

U.S.A.

13. FATHER'S NAME

William H. Smith

14. MOTHER'S MAIDEN NAME

Susan R. Crandall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

578-46-7922 Kathryne C. Dimmitt

Address 5801 Mass Ave. NW. Wash. D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Adenocarcinoma of Breasts

INTERVAL BETWEEN ONSET AND DEATH

4 years

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from

April 17, 1967 to May 3, 1967

that (I) (the hospital) saw the deceased alive on May 2, 1967, and that death occurred at 12 P.M. from the causes and on the date stated above

22a. SIGNATURE

Pr. M. Van Kinsbergen

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED May 3, 1967

22c. PHYSICIAN'S NAME (Type)

PR. M. VAN KINSBERGEN

22d. ADDRESS

5715 MASS AVE. DC 20016

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF 5-5-1967

23c. NAME OF CEMETERY OR CREMATORY

Congressional Cemetery Washington, D.C.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Joseph G. Wier's Sons, Inc. 5130 Wisconsin Ave. N.W. WASH. DC.

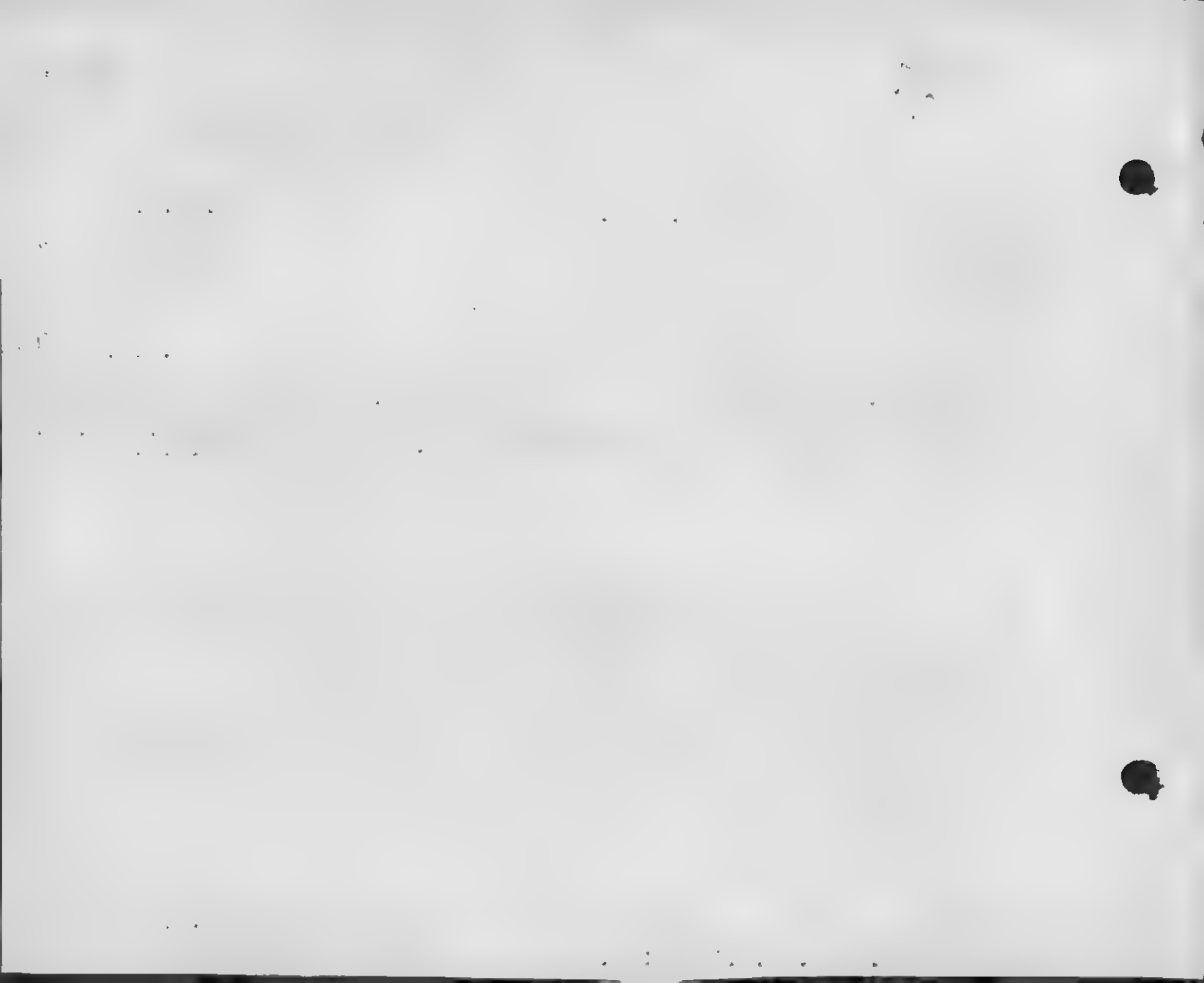
ADDRESS

25a. MAY 8 1967

DATE

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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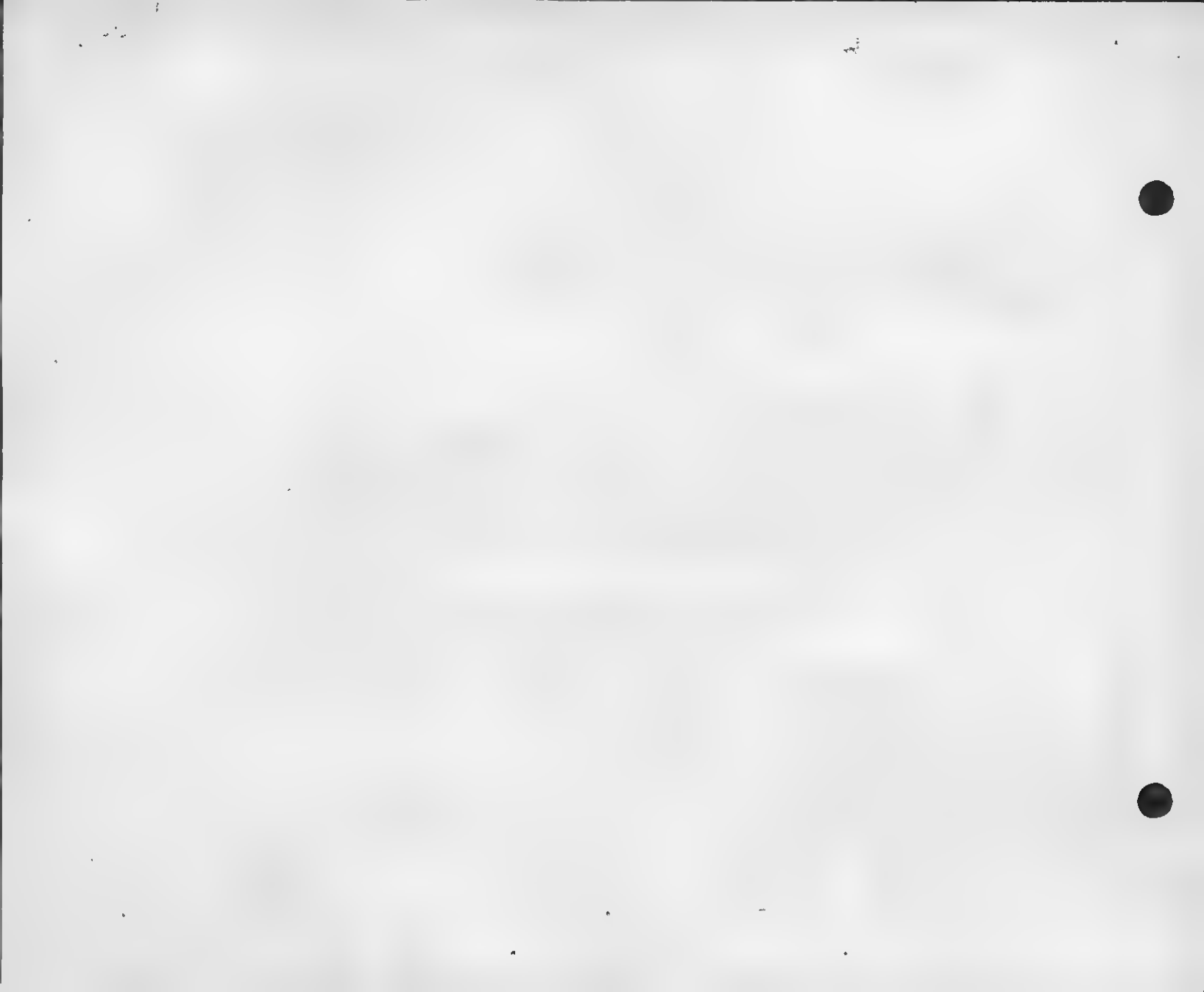
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06843

CERTIFICATE OF DEATH

06830

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c LENGTH OF STAY IN b <u>10 days</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Montgomery General Hospital</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Sandy Spring OLNEY</u> d STREET ADDRESS <u>3412 North High St. Olney Md.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Carolyn VERA Craver</u> First Middle Last		4 DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/13/95</u>
9 AGE (In years last birthday) <u>71</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12 KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME <u>George E. Nicholson</u>		14 MOTHER'S MAIDEN NAME <u>Blanche Young</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <u>X</u>		16 SOCIAL SECURITY NO <u>578-10-5382</u>	
17 INFORMANT <u>Hospital Record</u> Address <u>Olney Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema, acute</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 yrs</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>fall</u> , 1955, to <u>May</u> , 1967, that (I) (we) last saw the deceased alive on <u>May 14</u> , 1967, and that death occurred at <u>7:40</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Dr. D. Bonifant</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>Dement Bonifant</u>		22d ADDRESS <u>Medical Center Sandy Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>5-17-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d LOCATION (City or Town) (County) (State) <u>Olney Mont. Md.</u>
24 FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a RECD BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 16 1967</u>	
		25b REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

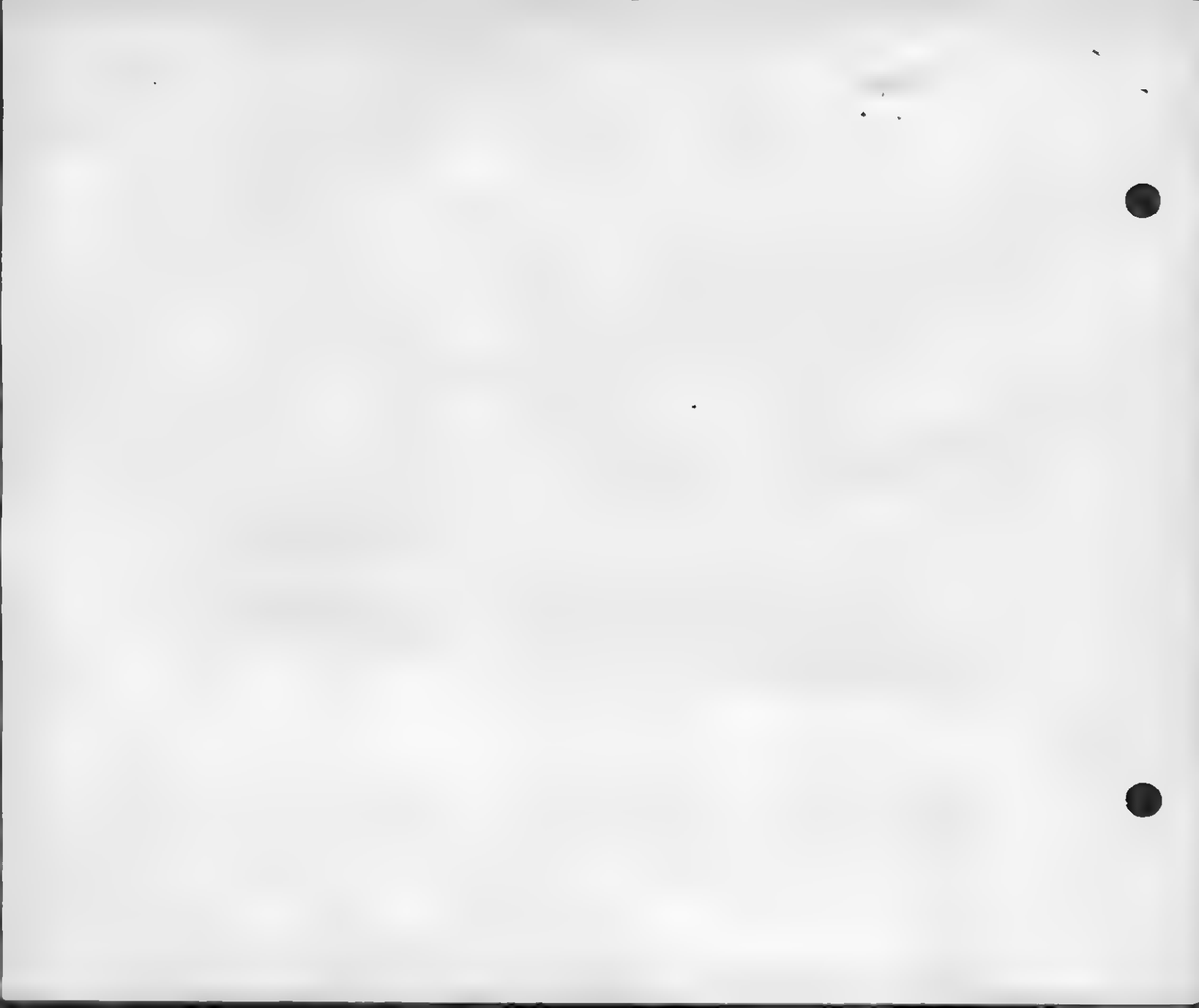
06844

06831

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Suburban</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>NEW YORK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>412 1/2 Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>C</u> Last <u>CROSS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-34</u>
9. AGE (In years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printing office</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>		11. BIRTHPLACE (County & State or foreign country) <u>Denison, Texas</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Roscoe A. Cross</u>	
14. MOTHER'S MAIDEN NAME <u>Callie M. Brooks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>456-20-8888</u>		17. INFORMANT <u>Wife (Rosamary Cross) Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic squamous CARCINOMA</u> DUE TO (b) <u>OF Lung From Rt Leg</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APR 1</u> 19 <u>67</u> to <u>MAY 19</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>MAY 18</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. H. E. DeLaughter</u>		22b. DATE SIGNED <u>May 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. H. E. DeLaughter</u>		22d. ADDRESS <u>3848 PORTER ST NW 4th Fl DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-22-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey Bethesda, Md. 20814</u>		25a. REC'D BY REGISTRAR <u>MAY 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

06845

06832

PLACE OF DEATH
COUNTY

MONTGOMERY

MARYLAND

USUAL RESIDENCE
STATE

MARYLAND

LENGTH OF STAY IN D

DOA

CITY OR TOWN & outside or

Bermentown

d NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address)

Suburban

d STREET ADDRESS

Rt. #2

3 NAME OF DECEASED
(Type or print)

BARNARD William CURTIS

4 DATE OF DEATH

MAY 23 1967

SEX

MALE WHITE

MARRIED

NEVER MARRIED

8 DATE OF BIRTH

AUG. 10, 1899

AGE

67

9 AGE

67

10 AGE

67

11 AGE

67

12 OCCUPATION (Give kind of work done)

TAXI DRIVER

13 KIND OF BUSINESS OR INDUSTRY

County Road

14 BIRTHPLACE (State or country)

District

15 FATHER'S NAME

JOHN Curtis

16 MOTHER'S MAIDEN NAME

Mary

17 WAS DECEASED EVER IN ARMED FORCES?

No

18 SOCIAL SECURITY NO

44-12-1222

19 INFORMANT

GEORGE W. CURTIS - SON

20 CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Myocardial infarction recent and remote

(b) Due to

Coronary occlusion

(c) Due to

Coronary arteriosclerosis

21 REAL DEATH AND BIRTH

24th

years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (List in Part I)

22 EXTERNAL CAUSE OF DEATH

PRIMARY OR CONTRIBUTING CAUSE OF DEATH

23 DEATH BE HOW INJURY OCCURRED (Enter nature of injury, Part I or Part II of it)

White

Not White

I certify that took charge of the person described above held an Autopsy ☒ Inquest ☒ and may opinion death resulted from Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Unexplained ☐

ACTUAL SIGNATURE

John G. Ball

CHIEF MEDICAL EXAMINER

ASST. CHIEF MEDICAL EXAMINER

EXAMINER'S NAME

John G. Ball Bethesda, Maryland

5/23/67

22. DATE SIGNED

Burial

5/25/67

Darnestown

Darnestown

Montg

Md

24 FUNERAL DIRECTOR

1331 Rock Pike

Tyson Wheeler Funeral Home Rockville, Md.

MAY 25 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in Item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 4 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

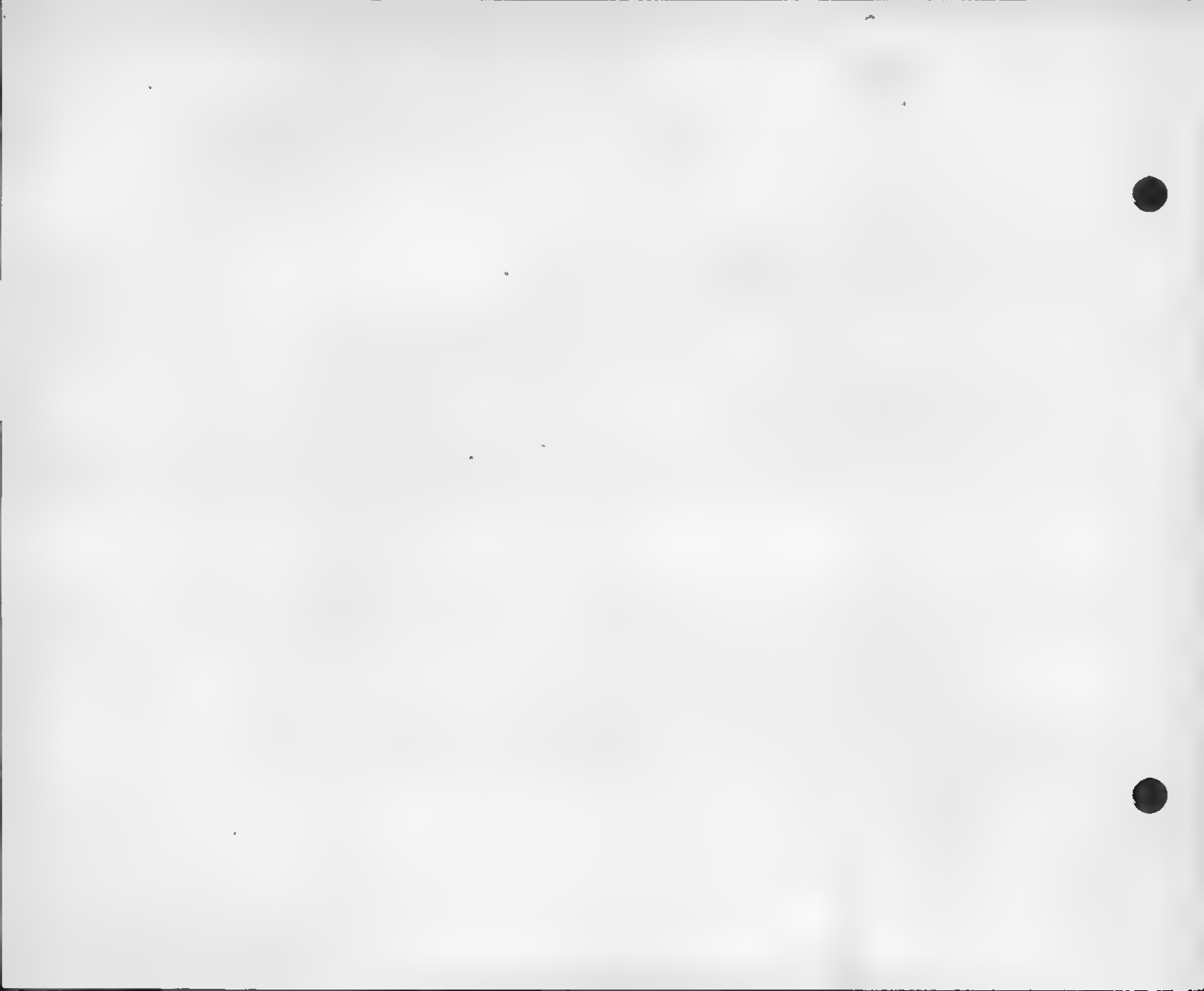
06846

06833

PLACE OF DEATH a. COUNTY MONTGOMERY		USUAL RESIDENCE b. STATE Maryland	
c. CITY OR TOWN Silver Spring		d. COUNTY Montgomery	
e. NAME OF HOSPITAL OR INSTITUTION 8609 Greenwood Ave.		f. STREET ADDRESS 8609 Greenwood Ave.	
NAME OF DECEASED WILLIAM OBER DAILEY, SR.		DATE OF DEATH May 9 1967	
SEX Male	COLOR OR RACE White	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH May 21, 1916
KIND OF BUSINESS OR INDUSTRY Painter		BIRTHPLACE (State or foreign country) Maryland	
FATHER'S NAME Ober Dailey		MOTHER'S MAIDEN NAME Mary	
WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		SOCIAL SECURITY NO 218 09 6850	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Calcific aortic stenosis		INTERVAL BETWEEN ONSET AND DEATH	
CONDITIONS (any which gave rise to immediate cause (a), stating the underlying cause last)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY CAUSE		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED May 9, 1967	
ACTUAL SIGNATURE Belden R. Keap		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME TYPE BELDEN R. KEAP, M.D.		ASSISTANT MEDICAL EXAMINER	
REMAINDER May 12, 1967		DEPUTY MEDICAL EXAMINER Charles J. Jones	
ADDRESS 254 Carroll St. N.W. D.C.		RECORDED BY MAY 12 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, and file Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

06847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06834

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate within the ward pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with this State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>MONTGOMERY</u>			
b CITY OR TOWN (If not de corporate limit write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY IN b <u>6 HRS</u>		c CITY OR TOWN (If not de corporate limit write RURAL and give nearest town) <u>SILVER SPRING</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASH SAN + HOSPITAL</u>				e STREET ADDRESS <u>230 Univ Blvd East</u>		f RESIDENT IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First Middle Last <u>LOUIS PAUL DARROW</u>				4 DATE OF DEATH Month Day Year <u>5 8 1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-7-96</u>		9 AGE (In years last birthday) <u>71</u> yrs	10 UNDER 1 YEAR Mo. <u>12</u> Day <u>15</u>	11 IF UNDER 24 HRS Hours <u>15</u> Mi <u>15</u>
10a USUAL OCCUPATION (Give kind of work done last of work ng life, even if retired) <u>Internal Revenue</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11 BIRTHPLACE (State or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>ERNEST DARROW</u>				14 MOTHER'S MAIDEN NAME <u>FANNIE ALISON</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes WW#1</u>		16 SOCIAL SECURITY NO		17 INFORMANT <u>CHART</u>			
18 CAUSE OF DEATH (Enter on y one cause per Part I or Part II) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Severe Intracranial</u> DUE TO <u>Hemorrhage due to Severe</u> (b) <u>Essential Hypertension</u> DUE TO (c) CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</u> <u>20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</u> <u>20c PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)</u> <u>20f (City or town) (County) (State)</u>							
20 TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20a INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type)				22. DATE SIGNED <u>May 9/1967</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b DATE THEREOF <u>5/12/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d LOCATION City or Town, (County) (State) <u>Cumberland, Maryland</u>	
24 FUNERAL DIRECTOR <u>The S. H. Hines Co Washington, DC</u>				25a REC'D BY REGISTRAR <u>MAY 10 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

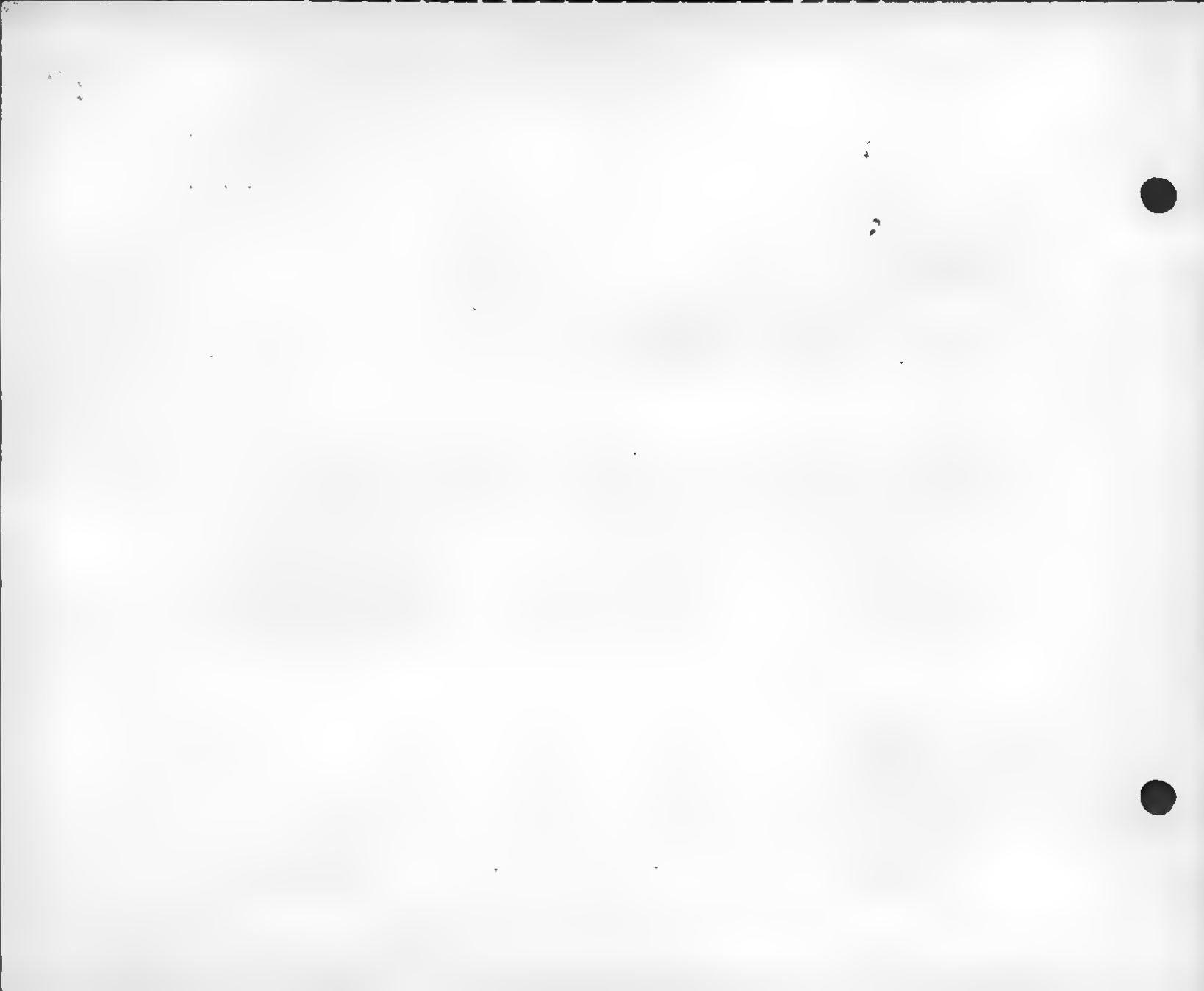
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06848

06835

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sil. Sprg. Md.</u>		c LENGTH OF STAY IN TB <u>Life</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		e STREET ADDRESS <u>108 Schuyler Rd. S.S.Md.</u>	
3 NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>S</u> Last <u>Davis</u>		4 DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/8/67</u>
9 AGE (in years) <u>4</u> last birthday		10 IF UNDER 1 YEAR Months <u>14</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12 KIND OF BUSINESS OR INDUSTRY <u>---</u>	
13 BIRTHPLACE (State or foreign country) <u>Takoma Park, WashSan. Md.</u>		14 COUNTRY OF WHAT COUNTRY? <u>USA</u>	
15 FATHER'S NAME <u>Morris Davis</u>		16 MOTHER'S MAIDEN NAME <u>Joyce Stockmair</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u>		18 SOCIAL SECURITY NO <u>---</u>	
19 INFORMANT <u>Joyce Davis</u>		Address <u>108 Schuyler Rd. S.S.Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) <u>47.1X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		IN INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden K. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN K. KEAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>5/17/1967</u>		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>May 18, 1967</u>	<u>King David Memorial Garden</u>	<u>Falls Church, Virginia</u>
24 FUNERAL DIRECTOR <u>Donald M. Stein</u> Funeral Home		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>232 Carroll St. N.W.</u>		DATE <u>MAY 19 1967</u>	
<u>Washington, D.C.</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
OM 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06849		06836	
PLACE OF DEATH a. COUNTY <u>Montgomery</u>		USUAL RESIDENCE b. STATE <u>Maryland</u> CITY <u>Montgomery</u>	
b. TYPE OR TOWN <u>Rural Boyd's</u> YEARS <u>years.</u>		c. TYPE OR TOWN <u>Rural Boyd's</u>	
d. NAME OF DECEASED <u>Reginald W. Davis</u>		e. STREET ADDRESS <u>Route 121</u>	
f. NAME OF DECEASED (Type or print) <u>Reginald W. Davis</u>		4. DATE OF DEATH <u>May 24 1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 6 1909</u>
9. BIRTHPLACE <u>Maryland</u>		10. BIRTHPLACE (State, city, town, etc.) <u>USA</u>	
11. FATHER'S NAME <u>Francis Davis</u>		12. MOTHER'S MAIDEN NAME <u>Lula Hager</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No.</u>		14. SOCIAL SECURITY NO. <u>220 266 974</u>	
15. INFORMANT <u>Calvin Davis</u>		Address <u>15303 Leeward Dr Silver Spring</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I CAUSE OF DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>			
(b) <u>1201</u> DUE TO			
(c) <u>1201</u> DUE TO			
PART II OTHER SIGNIFICANT CONDITION: CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21. I certify that I took charge of the <u>body</u> described above held at <u>A top</u> <input checked="" type="checkbox"/> <u>at</u> <input checked="" type="checkbox"/> <u>death resulted from</u> <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Other</u> <input type="checkbox"/>		22. DATE SIGNED <u>5/24/67</u>	
ACTUAL SIGNATURE <u>John B. Ball</u>		DEPUTY MEDICAL EXAMINER <u>X</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		Address (Street, city, town, or county) <u>Beallsville Mont. Md</u>	
Burial <u>5/27/67</u> <u>Monocacy</u>		Burial <u>5/27/67</u> <u>Beallsville Mont. Md</u>	
Hilton Funeral Home - Barnesville		MAY 31 1967	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

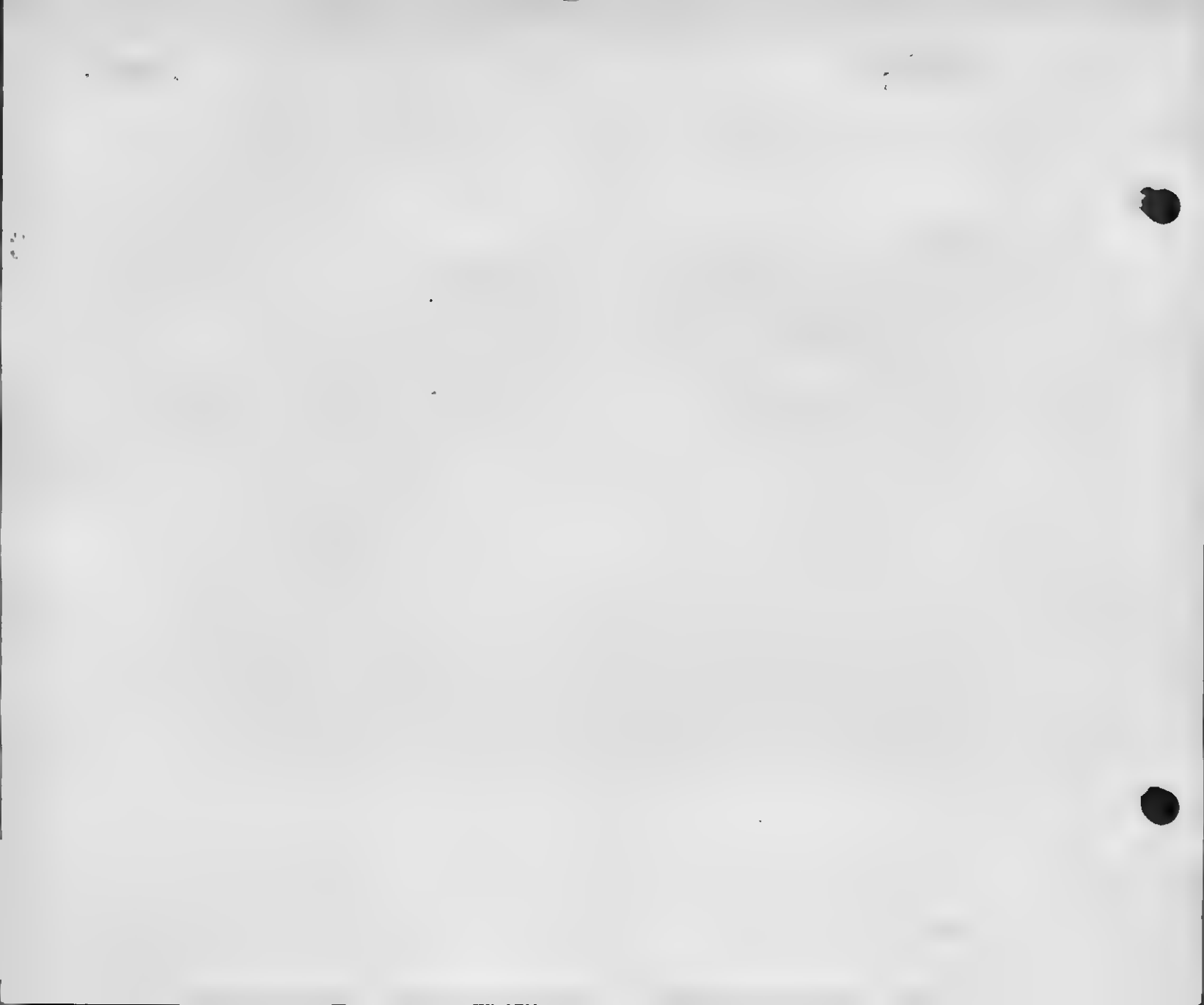
06850

06837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>107 Woodland Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Hezekiah</u> <u>Day</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u>		8. DATE OF BIRTH <u>Oct 17, 1911</u>	
9. AGE (In years, last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>6</u> Min. <u>15</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jacob Day</u>				14. MOTHER'S MAIDEN NAME <u>Susan Mills</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Woodrow W. Duwall. As No 2</u>			
17. INFORMANT <u>Woodrow W. Duwall. As No 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General arteriosclerosis</u> (c), stating the underlying cause last. <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1947 to 5-15-1957</u> , 1957 that (I) (we) last saw the deceased alive on <u>5-15-1957</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. J. B. Schant</u> M.D.				22b. DATE SIGNED <u>5-26-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. J. B. Schant</u>				22d. ADDRESS <u>11111 1st St. Gaithersburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) (State) <u>Gaithersburg</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Grier</u> ADDRESS <u>Gaithersburg, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>William C. Grier</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and any other action, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06851

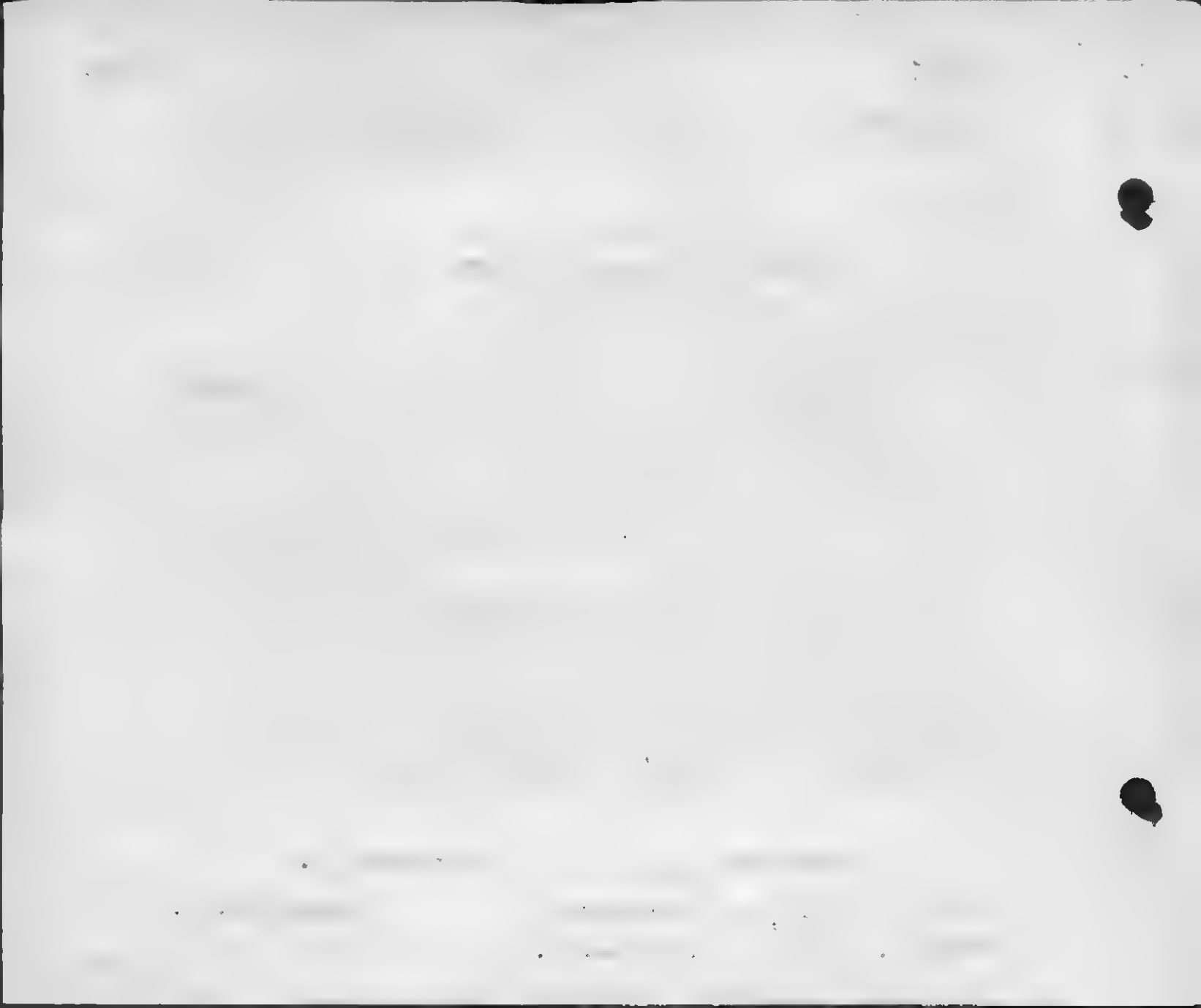
06838

1. PLACE OF DEATH
a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Montgomery c. LENGTH OF STAY IN lb 124
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Elizabeth's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 701 Boy 381-124

3. NAME OF DECEASED (Type or print) Joseph Asberry Day
4. DATE OF DEATH May 5 1967
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 11/17/91 9. AGE (In years) 76 11 MONTHS 5 DAYS 19 HOURS 67 MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10b. KIND OF BUSINESS OR INDUSTRY Marine 11. BIRTHPLACE, County & State or foreign country Maryland, U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Asberry Day 14. MOTHER'S MAIDEN NAME Ingalls
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 76-111-124 17. INFORMANT Flora Asberry

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct
DUE TO Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Diabetes Mellitus
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 9/18/61 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Frederick (State) Md.
21. I certify that (I) (this hospital) attended the deceased from 9/18/61 to 5/5/67, that (I) (we) last saw the deceased alive on 5/1/67, and that death occurred at 12:30 M., from the causes and on the date stated above.
22a. SIGNATURE Charles Ligon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE SIGNED 5/5/67
22b. PHYSICIAN'S NAME (Type) Charles Ligon ADDRESS Sandy Spring, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 8, 1967 23c. NAME OF CEMETERY OR CREMATORY Laytonsville 23d. LOCATION (City, town or county) Laytonsville, Md. (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md. 25a. REC'D BY REGISTRAR MAY 9 1967 25b. REGISTRAR'S SIGNATURE Charles Judge

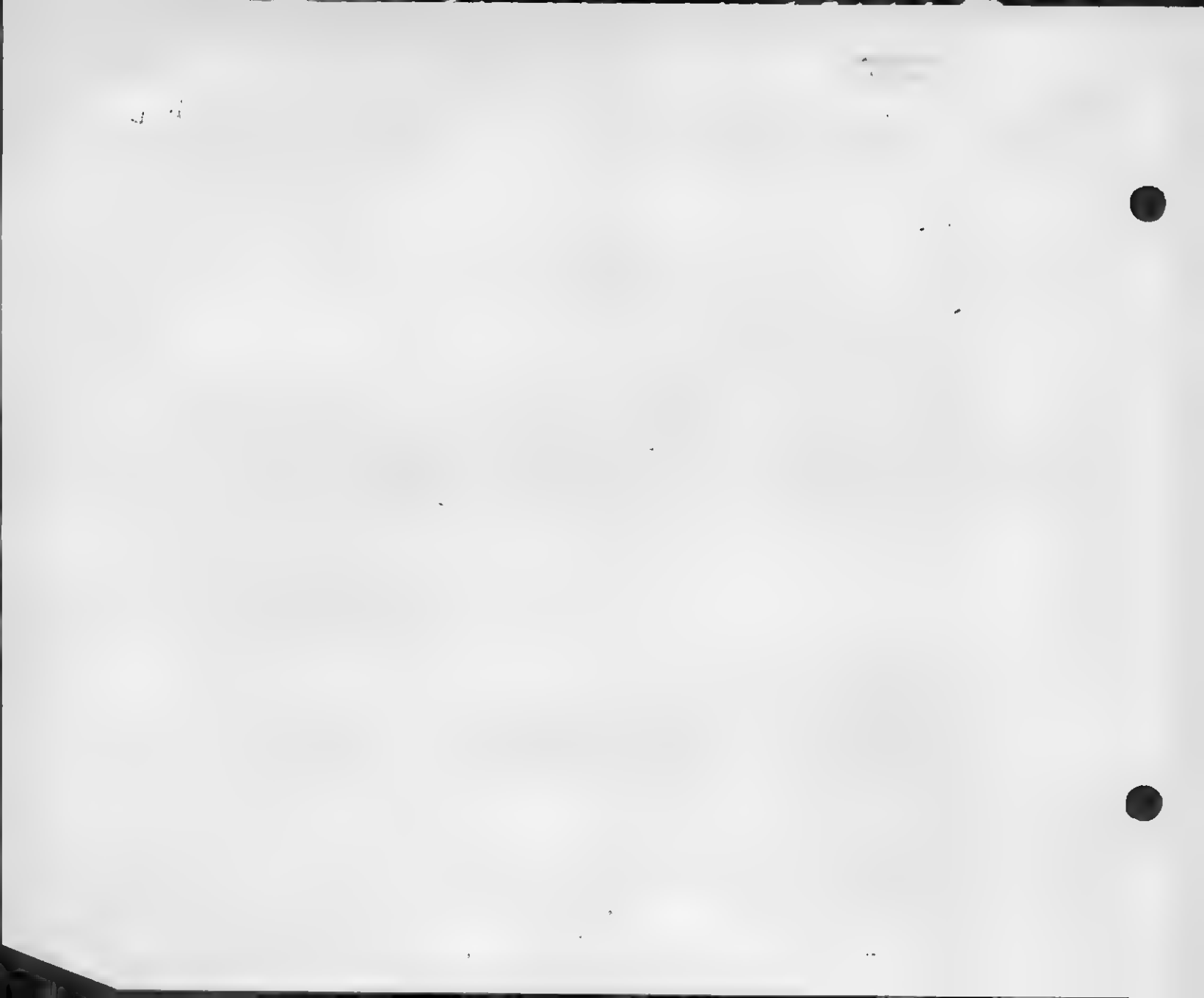


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06852 CERTIFICATE OF DEATH 06839

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althaus Woodland Nursing Home</u> <u>1000 Dakeview Dr.</u>		d. STREET ADDRESS <u>Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Emma</u> Last <u>Deer</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KING OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>George S. Deer</u>		14. MOTHER'S MAIDEN NAME <u>Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-56-2193</u>	
17. INFORMANT <u>Mrs. Corine D. Manger</u>		Address <u>3710 Woodbine Cherry Chase, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis, cerebral.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2nd day</u> <u>10 p.m.?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>64</u> to <u>May 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 8</u> , 19 <u>67</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip H. Varner</u>		22b. DATE SIGNED <u>5-21-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>10630 Georgia Ave., Taketon, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arcadia, Md.</u>
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>		25. REG'D BY REGISTRAR <u>MAY 24 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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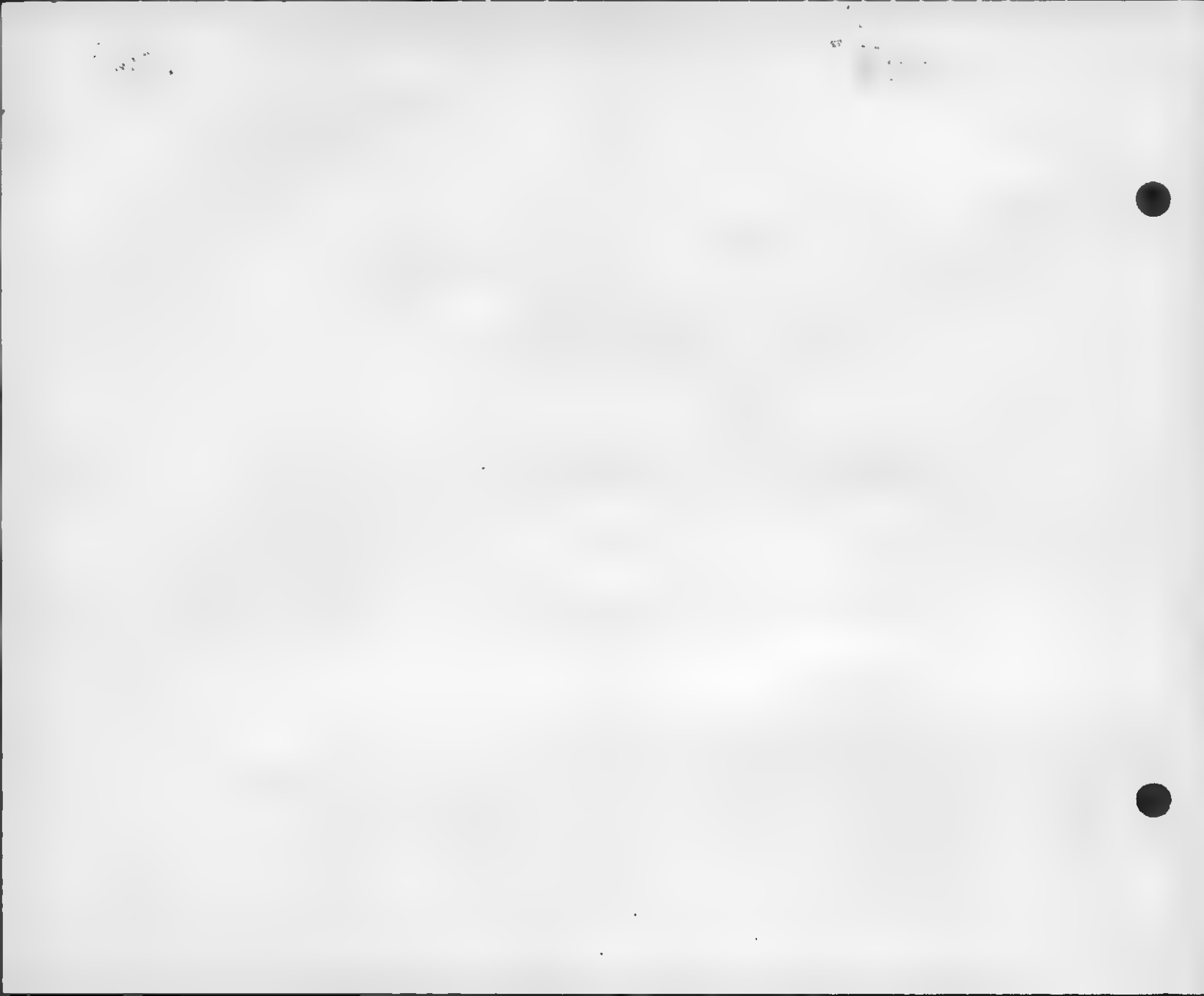
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06853

CERTIFICATE OF DEATH

06840

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Arizona</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY in 1b <u>1 day</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Fort Huachuca</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d STREET ADDRESS <u>106 B Mason Street</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Kevin William De Line</u>				4 DATE OF DEATH Month Day Year <u>May 8 1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>17 September 1966</u>	9 AGE (In years last birthday) yrs	F UNDER 1 YEAR Months Days	F UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (County & State or foreign country) <u>France</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William De Line</u>				14 MOTHER'S MAIDEN NAME <u>Peggy Kane</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT Address <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO (b) <u>Thrombocytopenia</u> DUE TO (c) <u>Acute Myelogenous Leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>25 hours</u> <u>3 Weeks</u> <u>3 Weeks</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7 May</u> , 19 <u>67</u> , to <u>8 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8 May</u> , 19 <u>67</u> , and that death occurred at <u>6:28 M.</u> , from causes and on the date stated above							
22a SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b DATE SIGNED <u>9 May 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Herbert E. Kann, Jr., MD.</u>				22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5/13/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Charleston, Missouri</u>	
24 FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> <u>Funeral Home</u> <u>4308 Suitland Road, Suitland, Maryland</u>				25a REC'D BY REGISTRAR DATE <u>MAY 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

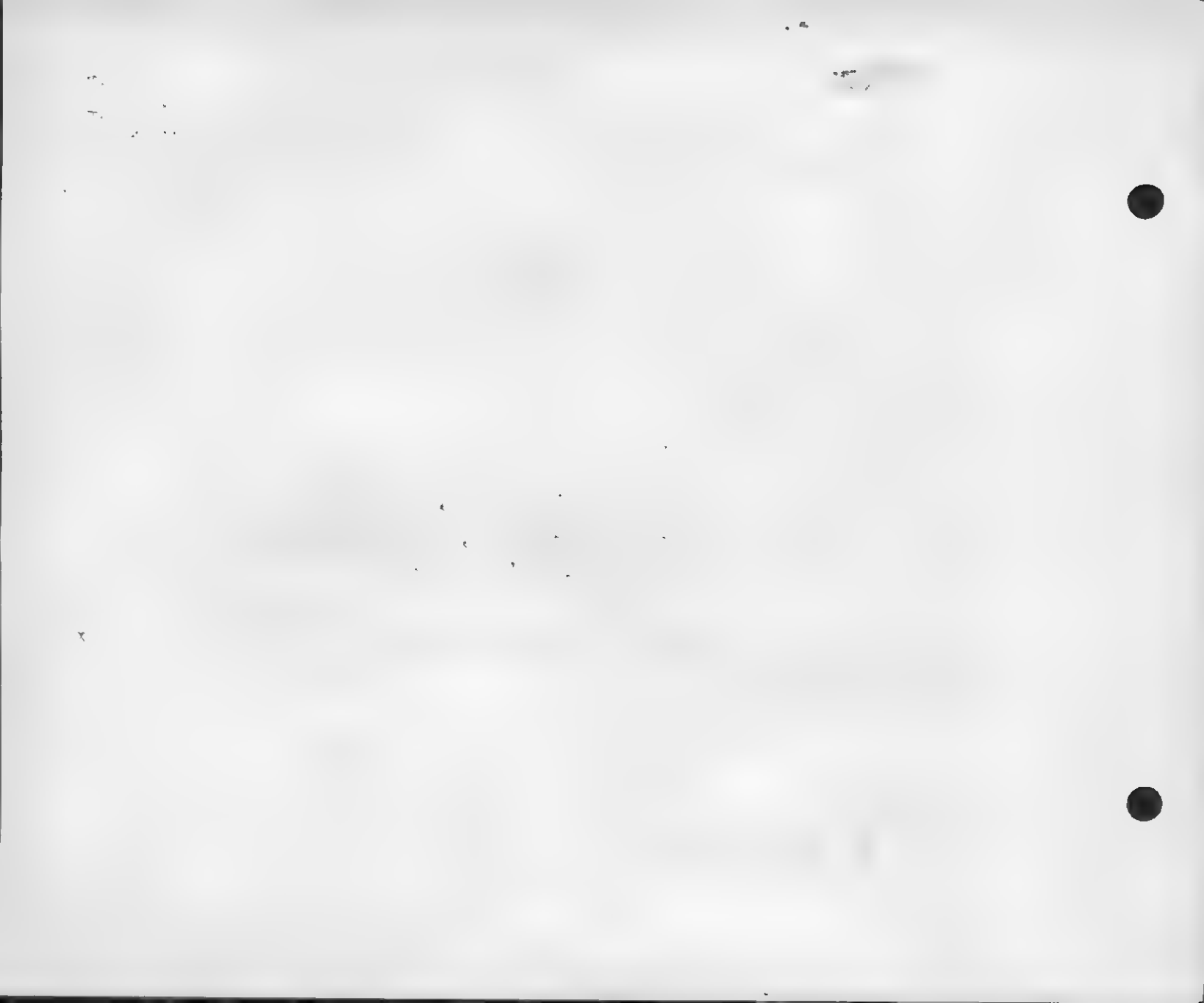
06854

06841

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Reside (e before admission) a STATE <u>MD</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suburban</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		d STREET ADDRESS <u>6514 E. 2nd Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Charles V</u> First <u>X</u> Middle <u>X</u> Last <u>X</u>		4 DATE OF DEATH <u>5-2</u> 19 <u>67</u> Month <u>5</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-18-1921</u> 4
9 AGE (In years last birthday) <u>45</u> yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Frederick, MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles V Xerney</u>		14 MOTHER'S MAIDEN NAME <u>Adeline Cook</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>577-28-8750</u>	
17 INFORMANT <u>James Xerney</u>		Address <u>---</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, massive</u> DUE TO (b) <u>Coronary thrombosis, left descending</u> DUE TO (c) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <u>Diabetes mellitus (controlled)</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>MAR. 21, 1967</u> to <u>MAY 2, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 2, 1967</u> , and that death occurred at <u>3 A.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>Lee M. Curtis</u> M.D.		22b DATE SIGNED <u>5-2-67</u>	22c PHYSICIAN'S NAME (Type) <u>LEE M. CURTIS</u>
22d ADDRESS <u>847 WISCONSIN AVE., BETHESDA, MD.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>5/4/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>
24 FUNERAL DIRECTOR <u>W.C. GAWLER & SONS, WASH., D.C. 20016</u>		25a REC'D BY REGISTRAR <u>MAY 8 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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FOR STATE HEALTH DEPT

06855

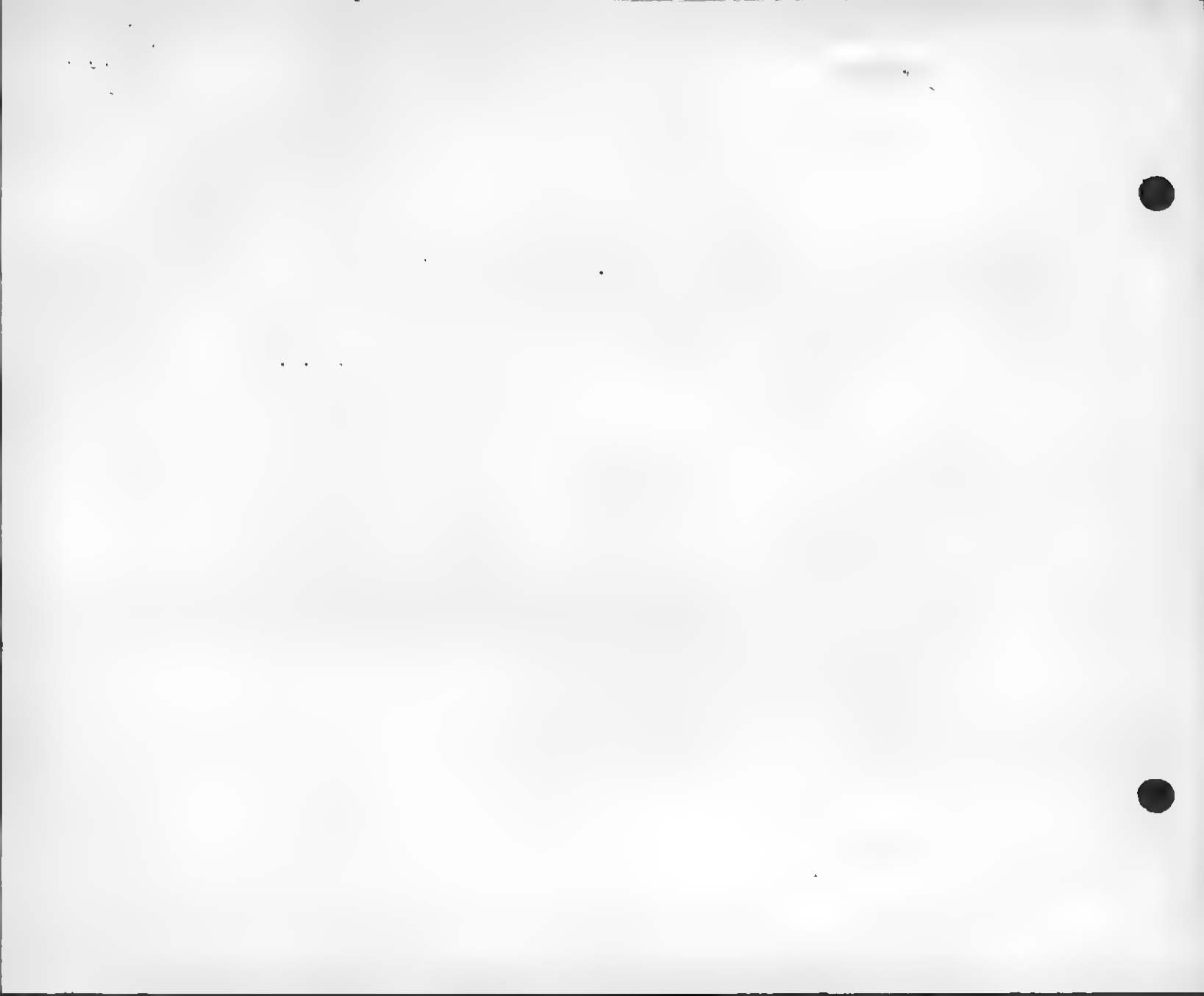
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06842

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in residence) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		d. STREET ADDRESS 1308 Woodside Parkway	
3 NAME OF DECEASED Type or print John NEVIN Ditzler		4 DATE OF DEATH Month May Day 25 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/9/11
9 AGE (In years last birthday) 55 yrs		10 IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Norman W. Ditzler		14. MOTHER'S MAIDEN NAME Hattie Emma Shade	
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO 578-01-768	
17 INFORMANT MILDRED P DITZLER		Address SAME AS #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) fall in boat DUE TO (b) fall in boat DUE TO (c) fall in boat CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. Was autopsy performed? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) 20c. TIME OF INJURY Month Day, Year 4:00 pm 5-29-67		20d. NATURE OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) On boat	
20f. (City or town) Annapolis		20g. (County) Annapolis	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED 5/26/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-29-67	
23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON		23d. LOCATION (City or town) ADELPHI	
23e. ADDRESS SILVER SPRING		23f. REC'D BY REGISTRAR JUN 2 1967	
23g. REGISTRAR'S SIGNATURE Charles Judge		23h. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

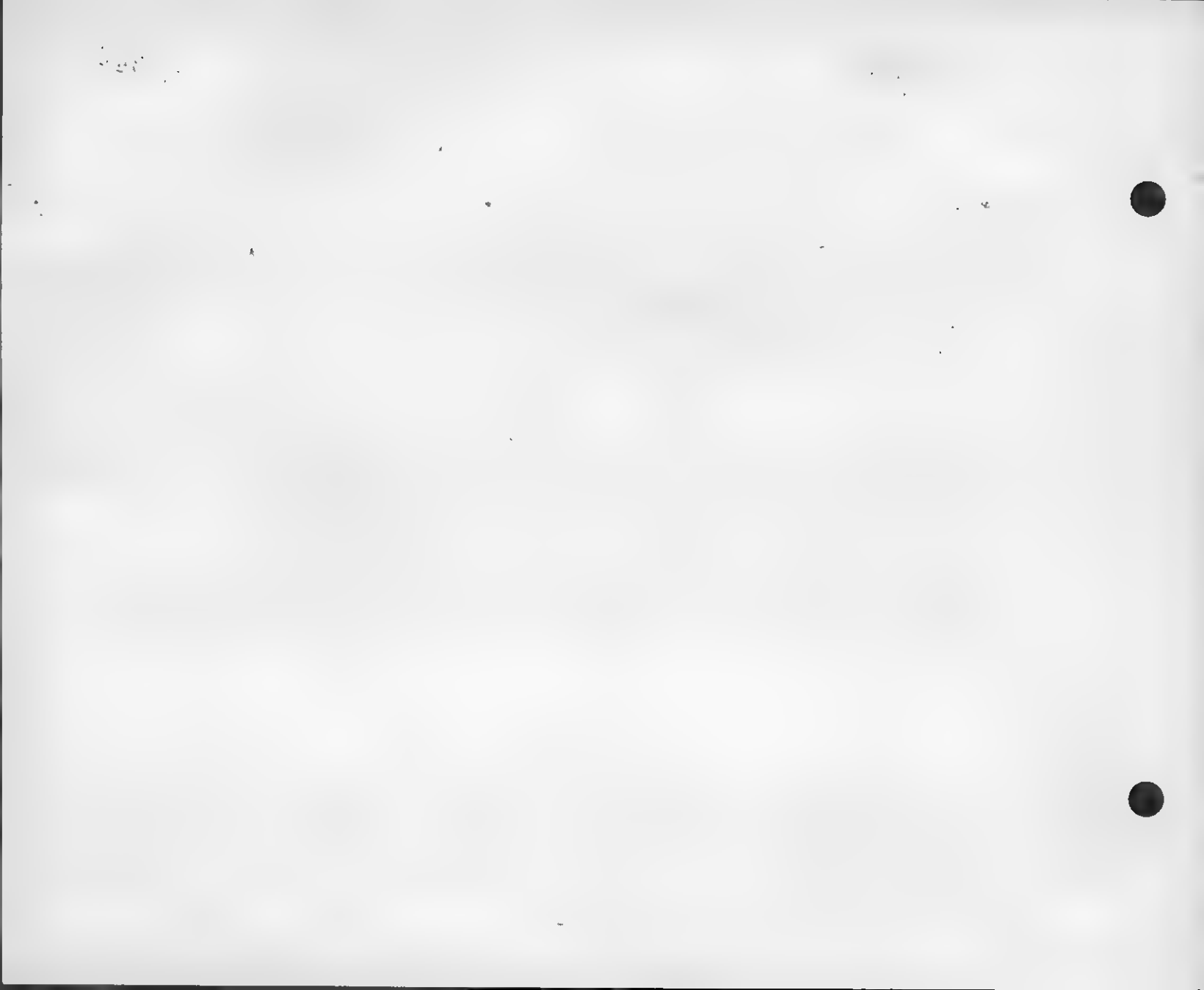
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06856

06843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>11</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2503 Newton St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2503 Newton St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>B</u> Last <u>Donaldson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 4, 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Ga.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William B Conley</u>						14. MOTHER'S MAIDEN NAME <u>Mariah Sparks</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-66-0474</u>				17. INFORMANT <u>Ivory C. Donaldson, same as #2.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 174 X DUE TO <u>carcinoma uterous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>5-4-67</u> (c)												INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/10/67</u> , 19 <u>67</u> , to <u>May 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.															
22a. SIGNATURE <u>Patrick J. Jamison</u>				22b. DATE SIGNED <u>5/12/67</u>				22c. PHYSICIAN'S NAME (Type) <u>Patrick J. Jamison</u>				22d. ADDRESS <u>11718 Georgia St. - Pk 96</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>May 15, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				23d. LOCATION (City, town or county) (State) <u>Pt. Geo. Co., Md.</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers & Co.</u>				25a. REC'D BY REGISTRAR <u>W-36, AC</u>				25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>				DATE <u>MAY 18 1967</u>			



06849

1. PLACE OF DEATH

Montgomery
Geney D.O.A.
Montgomery Gen. Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution. Residence before admission)
 a. STATE CA b. COUNTY LA

WASHINGTON
APR 23
912 VARNEY ST. S.E.

DORSEY
7/14/57

Male | Negro | WIDOWED ☐ | DIVORCED ☐ | ☒ NEVER MARRIED
done during most of working life, even if retired;
STUDENT

13. FATHER'S NAME

John BERNARD HENRY

14. MOTHER S MA DEN NAME

DORIS LOUISE DORSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. ☐ YES ☐ NO ☐ AL ☐ E. ☐ IRITY NC
(Yes, no, or unknown) (If yes give war or dates of service.)

MRS. DORETHA GILLIAM (FRIEND)

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Fracture of 6th cervical vertebra with
crushing of spinal cord.

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)

PARTIAL OTHER INCOME STATEMENT FOR THE YEAR ENDED 12/31/2011

MPC AL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY ☒ or CONTRIBUTING ☐
CAUSE OF DEATH.

2D6 DESCRIBE HOW INJURY OCCURRED (External cause of injury in P. 1) or Part II of Form

20b - DESCRIBE HOW INJURY OCCURRED (Explain type of injury in Part 1) of Part II accident.

Deceased child, a pedestrian, struck by
auto after alighting from bus.

20c. TIME OF INJURY

340

5-9.6'

1 I certify that

death res. 'or' 're

ACTUAL
SIGNATURE

EXAMINER:
B MF

2. A RIAL REVENUE

Removal (S) Burial

5/13/67

Harmony Memorial Cemetery Landover

Maryland

23. FUNERAL DIRECTOR

Universal Funeral Home

816 ^{ADDRESS} H St., N.E.
Washington, D. C.

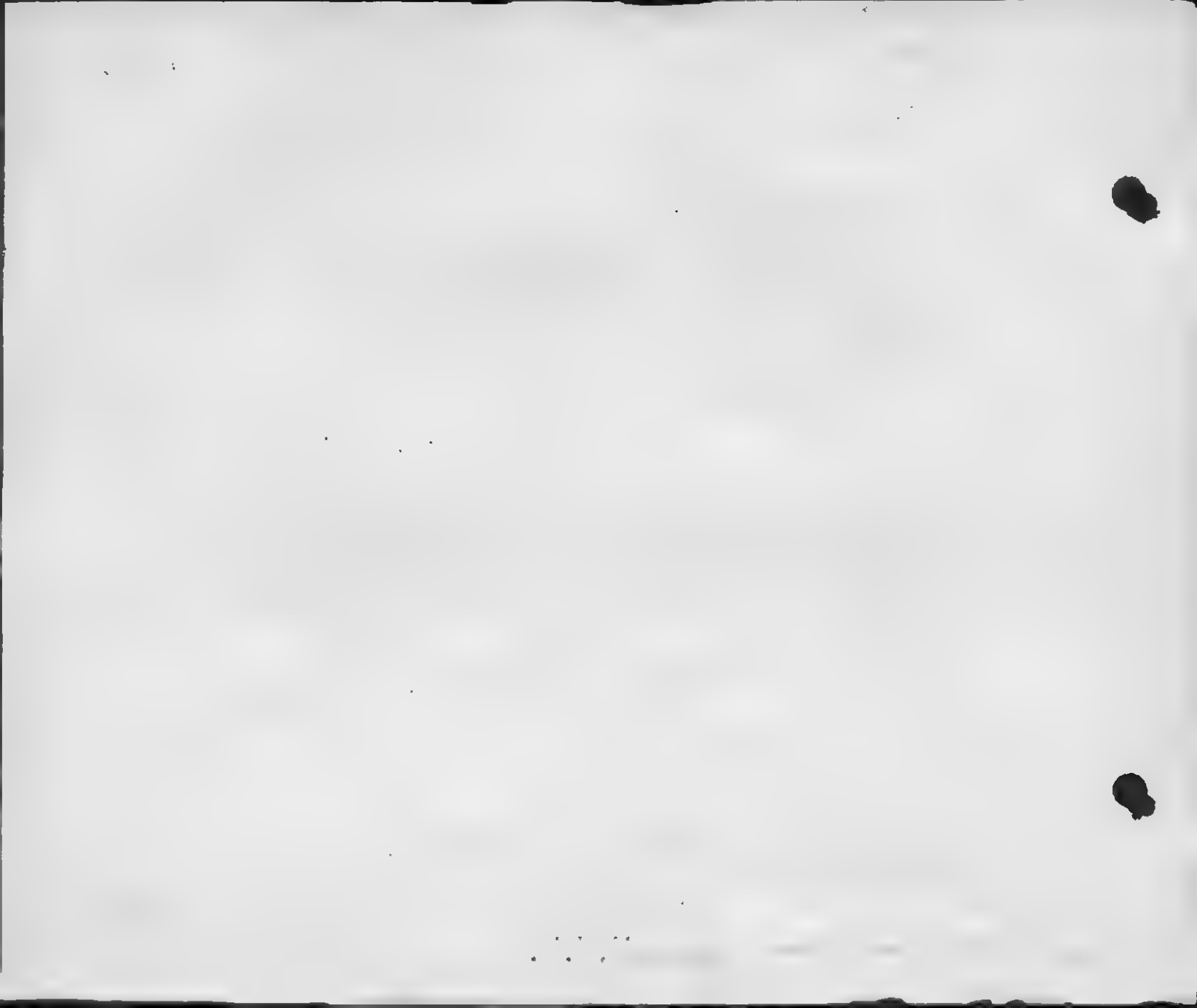
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE MAY 15 1967

Charles Judge

TO DEPUTY ATTORNEY GENERAL: The decedent's estate should be executed within 24 hours after death. I am please execute the will pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the file 4 should be filed with the Medical Examiner's Office along with form PM3. Page 5 may be retained TO FUNERAL DIRECTOR: The decedent should be used as a burial-transit permit. File pages 1 and 2 with the Health or its assignee agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06845

06858

FOR STATE HEALTH DEPT

PLACE OF DEATH

a COUNTY

Montgomery

Rockville

d NAME OF HOSPITAL OR INSTITUTE (If not in hospital, give street address)

12915 Greenable Dr.

NAME OF DECEASED (Type or print)

SEX

MALE

6 COLOR OR RACE

White

7 MARRIED

NEVER MARRIED

8 DATE OF BIRTH

Aug. 23, 1921

9 AGE (In years last birthday)

45

10 BIRTH-PLACE (State, Territory, Country)

Kansas

11 BIRTH-PLACE (City or town)

U. S.

12 BIRTH-PLACE (County)

U. S.

Operating Eng.

Govt.

Kansas

U. S.

13 FATHER'S NAME

Charles Edward Dowling, Sr.

14 MOTHER'S MAIDEN NAME

Rose January

15 WARD/DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16 SOCIAL SECURITY NO

511-09-4803

17 INFORMANT

wife

Same as Item 2.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE

451

CONDITIONS (only which gave rise to immediate cause (a) stating the underlying cause last

19

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20c TIME OF INJURY Month, Day, Year

19

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20d INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town)

(County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME

BELDEN R. REAP

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY ASSISTANT MEDICAL EXAMINER

22. DATE SIGNED

5/20/1967

23a REMOVAL (Specify)

Burial

23b DATE THEREOF

5-24-67

23c NAME OF CEMETERY

Walnut Cemetery

23d ADDRESS

Walnut, Kansas

24 FUNERAL DIRECTOR

ROBERT A. PUMPHREY, Bethesda, Maryland

25a REC'D BY REGISTRAR

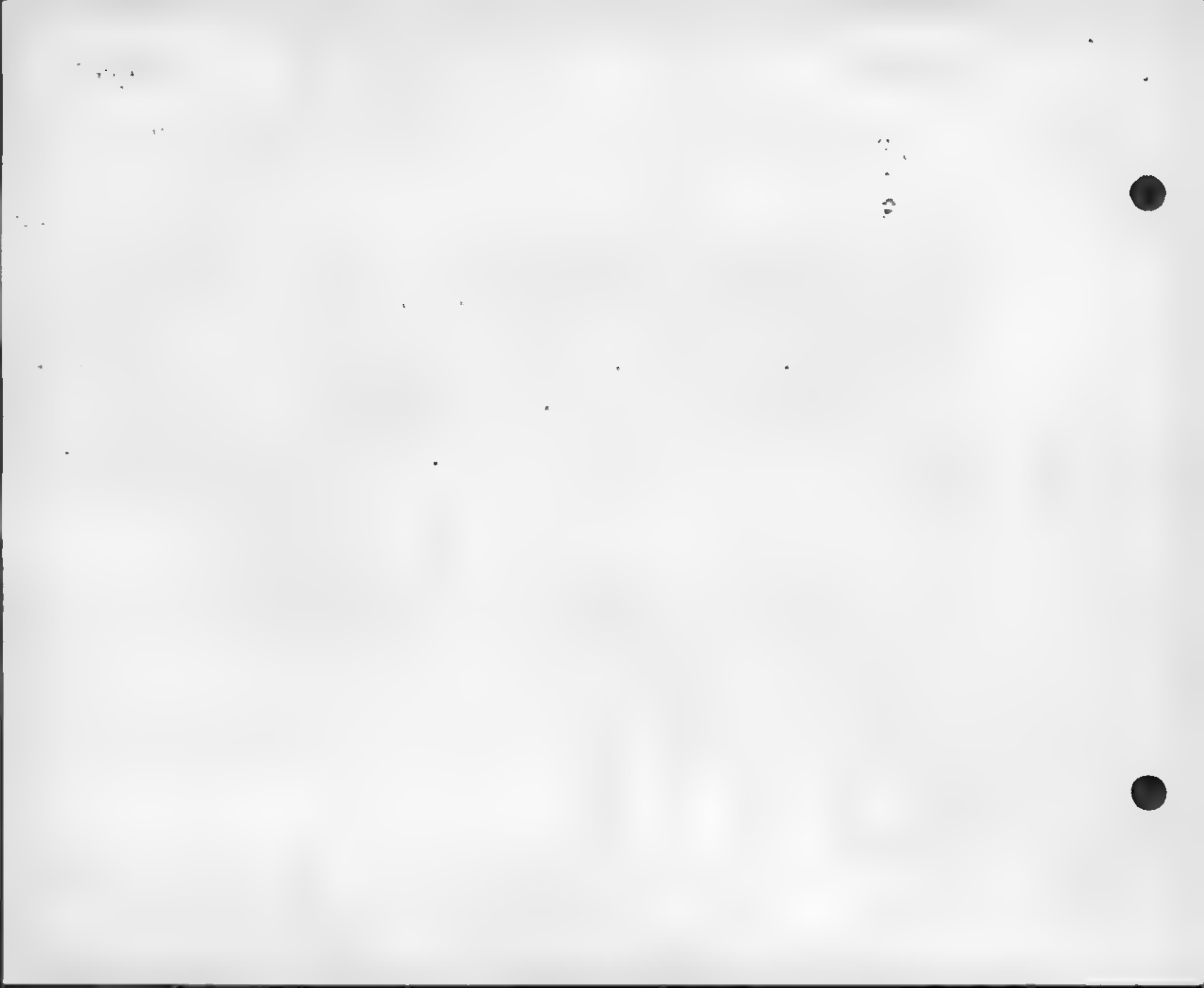
MAY 24 1967

25b REGISTRAR'S SIGNATURE

Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MD 2013
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-3131

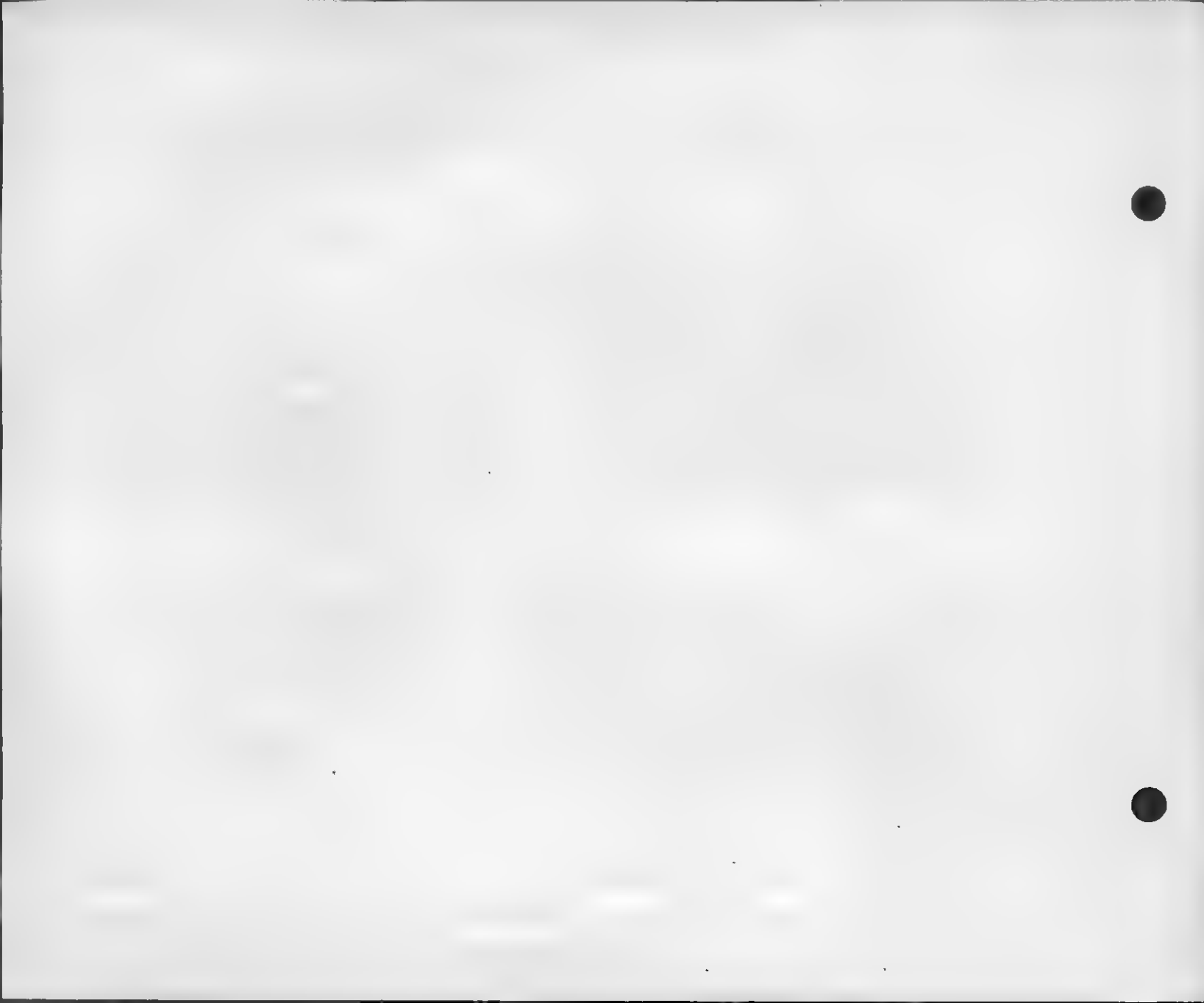
CERTIFICATE OF DEATH

05330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c LENGTH OF STAY N 16 <u>2 weeks</u>			c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d STREET ADDRESS <u>3408 Farthing Drive</u>			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Frances Doyle</u>				4 DATE OF DEATH Month Day Year <u>5 31 19 67</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-23-1913</u>		9 AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11 BIRTHPLACE (Country & State or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Martin Gavin</u>				14 MOTHER'S MAIDEN NAME <u>Anna McLaughlin</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Edward Doyle</u> <u>3408 Farthing Drive</u> <u>Wheaton, Maryland</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis liver</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f City or town County State
21 I certify that (I) (this hospital) attended the deceased from <u>12/67</u> , 19 <u>67</u> to <u>5/30/67</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive <u>5/30/67</u> , 19 <u>67</u> , and that death occurred at <u>11 P</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>Patrick C. Garrison</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b DATE SIGNED <u>6/1/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Patrick C. Garrison</u>			22d ADDRESS <u>11718 George A Silver Sp. Rd</u>				
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>June 5, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d LOCATION (City or town, County, State) <u>Silver Spring, Maryland</u>	
24 FUNERAL DIRECTOR <u>C. Glen Satter</u>				25a RECEIVED BY REGISTRAR <u>JUN 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>A. Jones</u>	



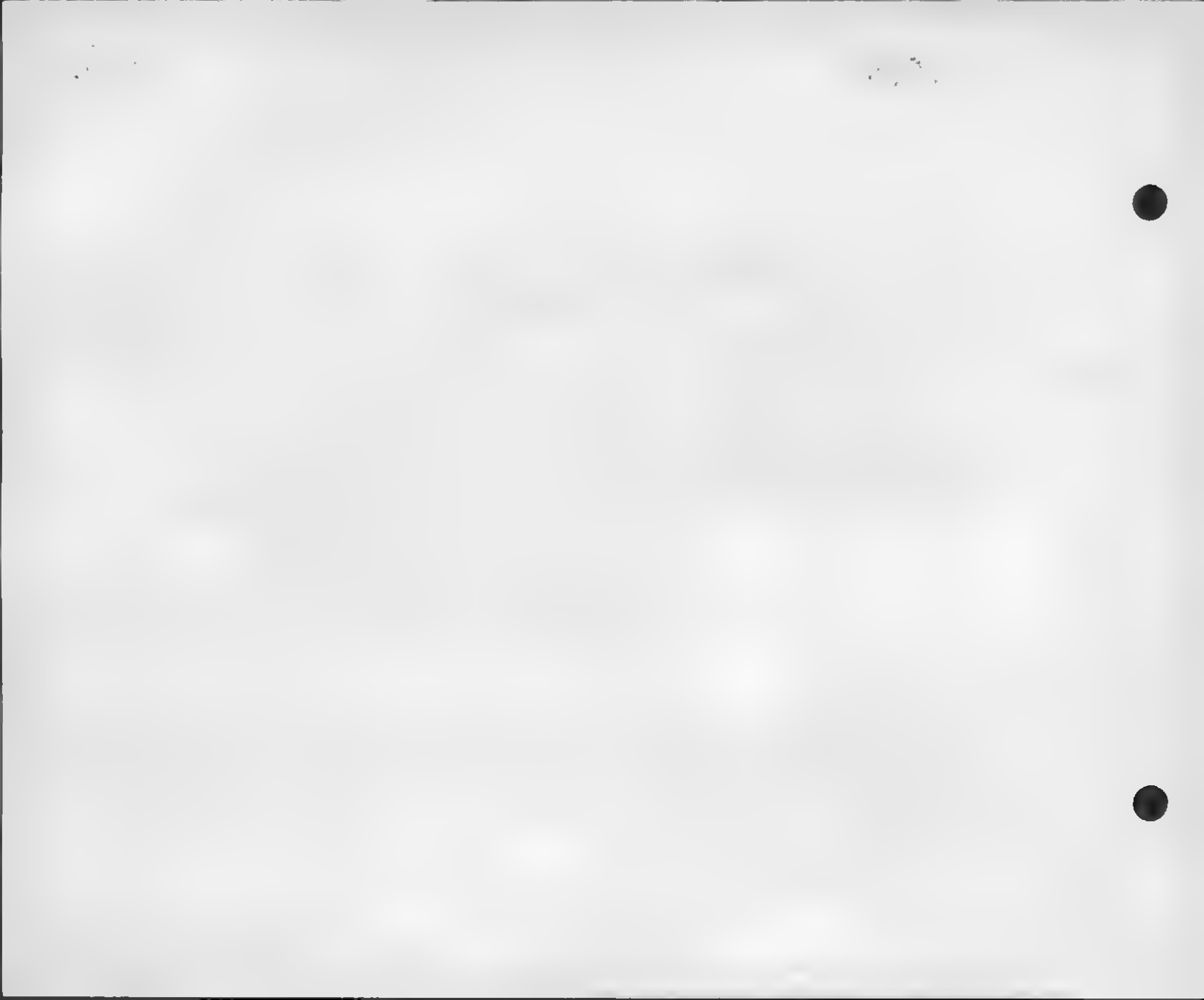
06859

06846

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pakoma Park		c. LENGTH OF STAY IN 1b 5 hours		2 USUAL RESIDENCE (Where deceased lived, if institution. Res. before admission) a. STATE Washington D. C.		b. COUNTY Washington D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3 NAME OF DECEASED (Type or print) Agnes Cecelia Dusterhoff		4 DATE OF DEATH Month 5 Day 3 Year 1967		5 SEX Female	
6 COLOR OR RACE White		7 MARKED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-5-88		9. AGE (In years last birthday) 79 yrs		F UNDER 1 YEAR Months 1 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if ret. red.) Housewife - Ret. Clerk Treasury Dept.		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.		11. BIRTHPLACE (County & State or foreign country) America		12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Jacob Elbert	
14. MOTHER'S MAIDEN NAME Mary O'Connor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-54-3635		17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Hypertensive Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that (I) (this hospital) attended the deceased from Aug 14, 1957 , to May 3, 1967 , that (I) (we) last saw the deceased alive on May 2, 1967 , and that death occurred at 12:02 PM , from causes and on the date stated above			
22a. SIGNATURE Philip E. Jones M.D.		22b. DATE SIGNED 5/3/67		22c. PHYSICIAN'S NAME (Type) Philip E Jones MD		22d. ADDRESS 800 Pershing Dr NW Silver Spring Md 20910			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR The S H Jones & Co 2701-14th St NW		25a. REC'D BY REGISTRAR MAY 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06860

06847

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY in b. 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 14118 COLUMBIA ROAD	
3 NAME OF DECEASED (Type or print) First MAUDE Middle IRENE Last DUVALL		4. DATE OF DEATH Month MAY Day 12 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/99
9. AGE (in years last birthday) 67 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (County & State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD MUSGROVE	
14. MOTHER'S MAIDEN NAME BELL MILLSTEAD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO		17. INFORMANT MEDICAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Acute Gastritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Diabetes Mellitus. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture surgical neck of humerus			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 5/12/67 to 5/12/67 that () (we) lost the deceased alive on 5/12/67 and that death occurred at 4:30 PM , from cause and on the date stated above			
22a SIGNATURE C.H. LIGON, M.D.		22b DATE SIGNED 5/12/67	
22c PHYSICIAN'S NAME (Type) C.H. LIGON, M.D.		22d ADDRESS SANDY SPRINGS MED. CENTER, SANDY SPRGS.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 5-15-67	
23c NAME OF CEMETERY OR CREMATORY Lincoln Cem		23d LOCATION (City or town) (County) (State) Burtonsville Md.	
24 FUNERAL DIRECTOR Wm. H. Thompson		25a REC'D BY REGISTRAR MAY 17 1967	
		25b REGISTRAR'S NAME Johnnie Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

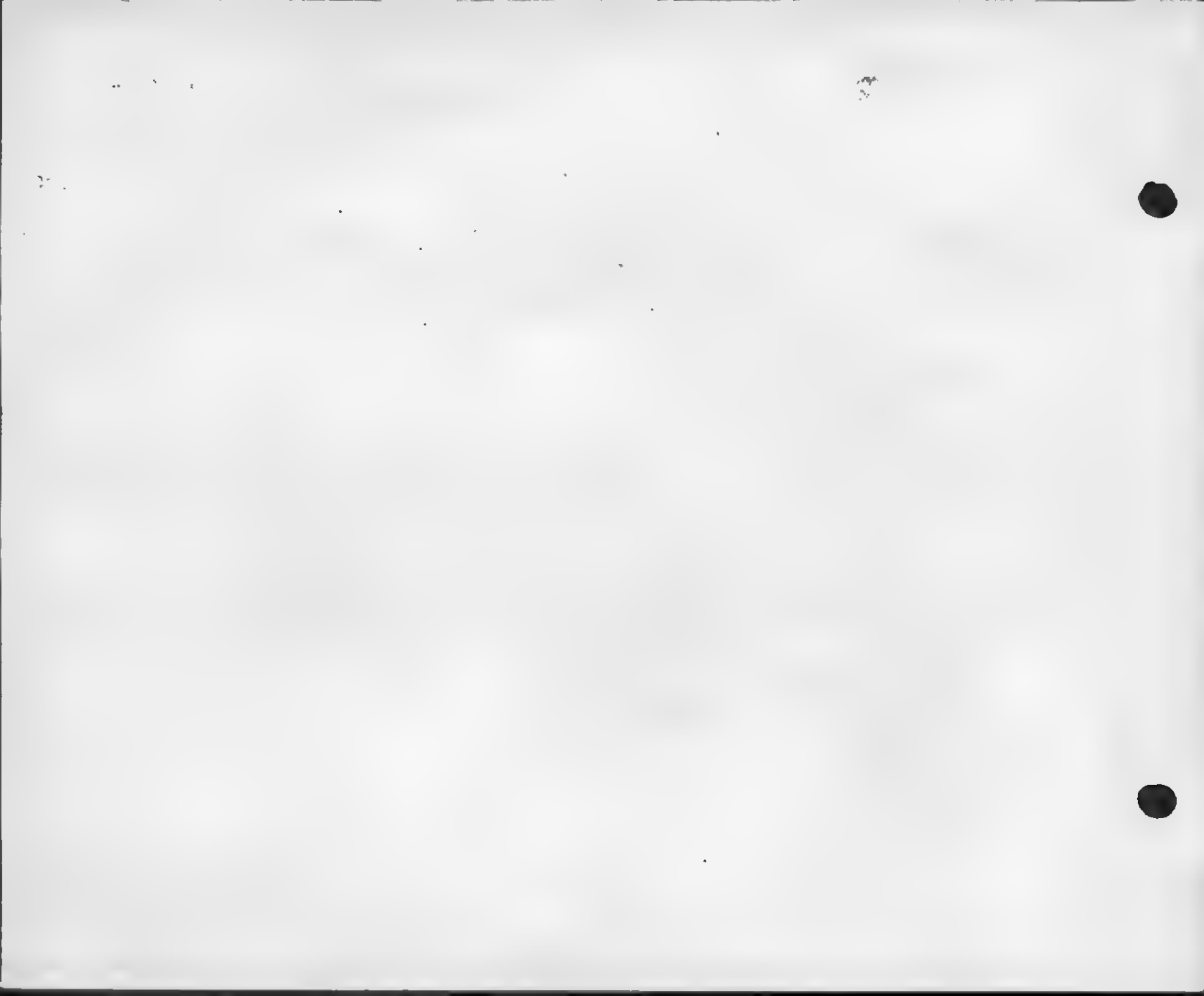
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06861

CERTIFICATE OF DEATH

06848

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admiss on) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>			c LENGTH OF STAY IN 1b <u>2 days/1 hr/50 min</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d STREET ADDRESS <u>735 Sligo Ave. Apt. 202</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>E. DNR</u> XXXXXXXXXX <u>EISENHART</u>				4 DATE OF DEATH <u>May</u> <u>24</u> <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 29, 1898</u>	9 AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11 BIRTHPLACE (County & State or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>CHARLES DEVERS</u>				14 MOTHER'S M A DEN NAME <u>Esther Price</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of serv ice) <u>NO</u> <u>None</u>		16 SOCIAL SECURITY NO <u>577-28-8071</u>		17 INFORMANT <u>Elizabeth Eisenhart</u> <u>735 Sligo Ave.</u> XXXXXXXXXXXXXXXXXXXXXXXXXXXX			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Obstruction</u> DUE TO <u>Tracheal obstruction</u> DUE TO <u>Carcinoma of the Thyroid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>None</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day Year Hour am pm <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f (City or town) (County) (State)		
21 I certify that (1) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>67</u> , to <u>4/27</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>4-24</u> 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>John J. Smith</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>5-24-67</u>			
22c PHYSICIAN'S NAME (Type) <u>John J. Smith, M.D.</u>		22d ADDRESS <u>4444 Lehigh Ave. N.W.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 27, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>48434 Georgia Avenue Silver Spring, Md.</u>		25a RECD BY REG STRAR DATE <u>MAY 26 1967</u>		25b REG STRAR'S SIGNATURE <u>William Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06862

06849

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Mont</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c LENGTH OF STAY IN 1b <u>23 hours</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>6711 Needwood Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Emma Eubank</u>		4 DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-31-56</u>
9 AGE (in years last birthday) <u>11</u> yrs		10 F UNDER 1 YEAR Months Days Hours Min	
10a US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 PLACE OF BIRTH (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John L. Eubank</u>		14 MOTHER'S MAIDEN NAME <u>Rose Myers</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>John L. Eubank</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Congenital heart disease</u> DUE TO (c) <u>congenital heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>congenital heart disease.</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>3:15 p.m.</u> 19 <u>67</u> to <u>2:45</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>4/4/67</u> 19 <u>67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>W. G. Hall</u>		22b DATES GIVEN	
22c PHYSICIAN'S NAME (Type) <u>W. G. Hall M.D.</u>		22d ADDRESS <u>6711 Needwood Rd.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>5/5/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>Edna C. Smith</u>		25a READ BY REGISTRAR DATE <u>MAY 8 1967</u>	
25b REGISTRAR'S SIGNATURE <u>John L. Eubank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06863

CERTIFICATE OF DEATH

06850

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE District of Columbia c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS 4418 Albermarle St., N. W.	
3 NAME OF DECEASED (Type or print) First Carlos Middle A. Figueira Last e DATE OF DEATH Month May Day 4 Year 1967		f RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 4, 1967
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b KIND OF BUSINESS OR INDUSTRY N/A	11 BIRTHPLACE (County & State or foreign country) Montgomery Md.
13 FATHER'S NAME Carlos A. Figueira		14 MOTHER'S MAIDEN NAME Edna Correia de Castilhofilha	
9 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) N/A		16 SOCIAL SECURITY NO. N/A	17 INFORMANT Washington D.C. Carlos A. Figueira, 4418 Albermarle St. N.W.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 75 Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple congenital anomalies (c) Trisomy 13-15			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town, county, state)
21. I certify that (I) (this hospital) attended the deceased from May 4, 1967 to May 4, 1967 . that (we) last saw the deceased alive on May 4, 1967 , and that death occurred at 1121 AM from cause and on the date stated above			
22a SIGNATURE T. E. Kelly		22b DATE SIGNED 8 May 1967	
22c PHYSICIAN'S NAME (Type) T. E. KELLY, M. D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Transfer	23b DATE THEREOF 5 May 1967	23c NAME OF CEMETERY OR CREMATORY Naval Medical School, NMMC Bethesda, Md.	23d LOCATION (City or town, county, state)
24 FUNERAL DIRECTOR		25a RECEIVED BY REGISTRAR MAY 10 1967	25b REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

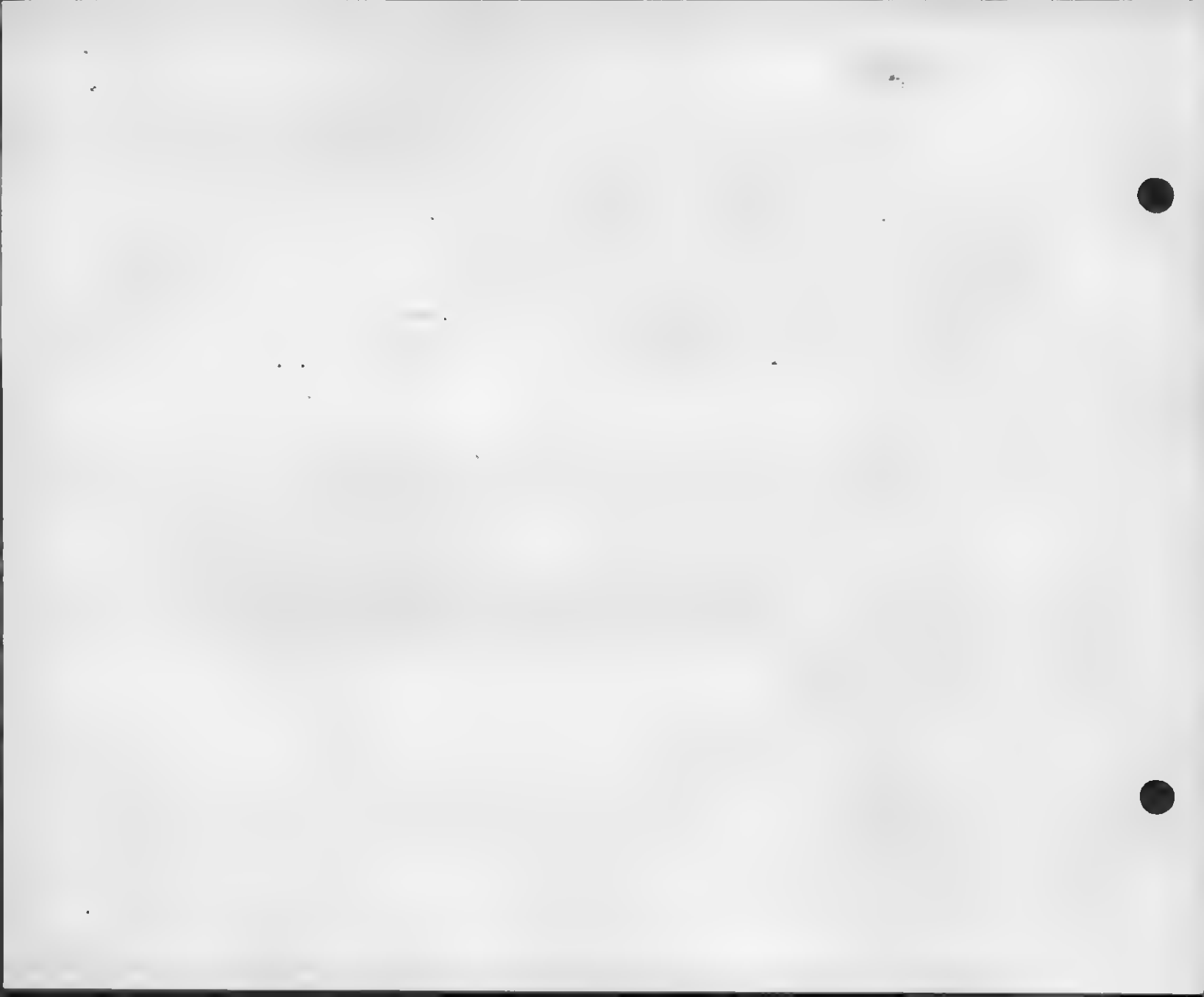
06864

06851

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a STATE Maryland b COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN IL 9 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e STREET ADDRESS 3211 Toledo Place	
3 NAME OF DECEASED (Type or print) Fred J. Filla		4 DATE OF DEATH Month May Day 25 Year 1967	
5 SEX MALE	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 23, 1909
9 AGE (in years last birthday) 57 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Food Manager		10b KIND OF BUSINESS OR INDUSTRY Giant Foods	
11 BIRTHPLACE (Country & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George A. Filla		14 MOTHER'S MAIDEN NAME Sadie Laruz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 577-18-4732	
17 INFORMANT Mrs. Sallie F. Filla		Address 3211 Toledo Place	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA DUE TO (b) BRONCHOGENIC CARCINOMA RIGHT LUNG DUE TO (c) 16 MONTHS		INTERVAL BETWEEN ONSET AND DEATH 2-4 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1954 to 25-MAY, 1967 , that (I) (we) last saw the deceased alive on 24 MAY 1967 , and that death occurred at 3:10 AM , from causes and on the date stated above			
22a SIGNATURE Henry B. Wolfe M.D.		22b DATE SIGNED 5/25/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/29/67	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24 FUNERAL DIRECTOR Home Inc.		25a REC'D BY REGISTRAR MAY 31 1967	
25b REGISTRAR'S SIGNATURE atc.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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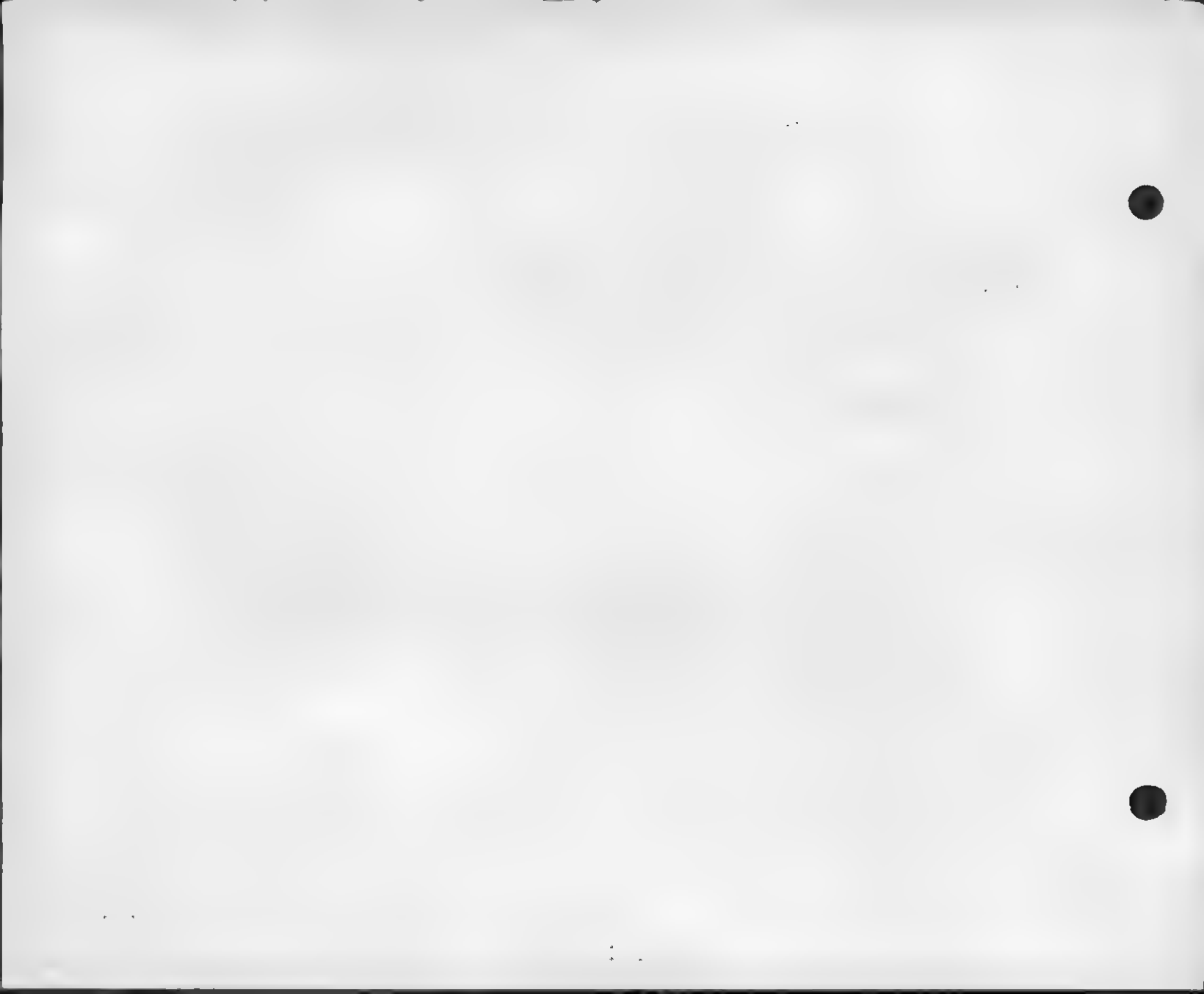
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARY. AND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <u>D.C.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>5310 42nd St.</u>	
3 NAME OF DECEASED (Type or print) <u>Arthur P. Fitzgerald</u> First Middle Last		4 DATE OF DEATH <u>5-30</u> Month Day Year 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 15, 1897</u> 9 AGE (in years last birthday) <u>69</u> yrs
10a USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>Retired - Traffic Supv. Eve Star Newspaper</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11 BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY	
13 FATHER'S NAME <u>George Fitzgerald</u>		14 MOTHER'S MAIDEN NAME <u>Ida F. Harvey</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>578-10-2236</u>	
17 INFORMANT <u>Wife - Bonnie - Same</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I CAUSE OF DEATH AS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Chronic glomerulonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. pm <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.)	20f (City or town, County, State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>5-30-1967</u> and that (I) (we) last saw the deceased alive on <u>5-30-1967</u> and that death occurred at <u>2 PM</u> from causes and on the date stated above.			
22a SIGNATURE <u>J. P. Andrews</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>J. P. ANDREWS M.D.</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>6-2-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d LOCATION (City or town, County, State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u> Ave. <u>1300</u> Wash. D.C.		25a REC'D BY REGISTRAR <u>ILN</u> DATE <u>1007</u>	25b REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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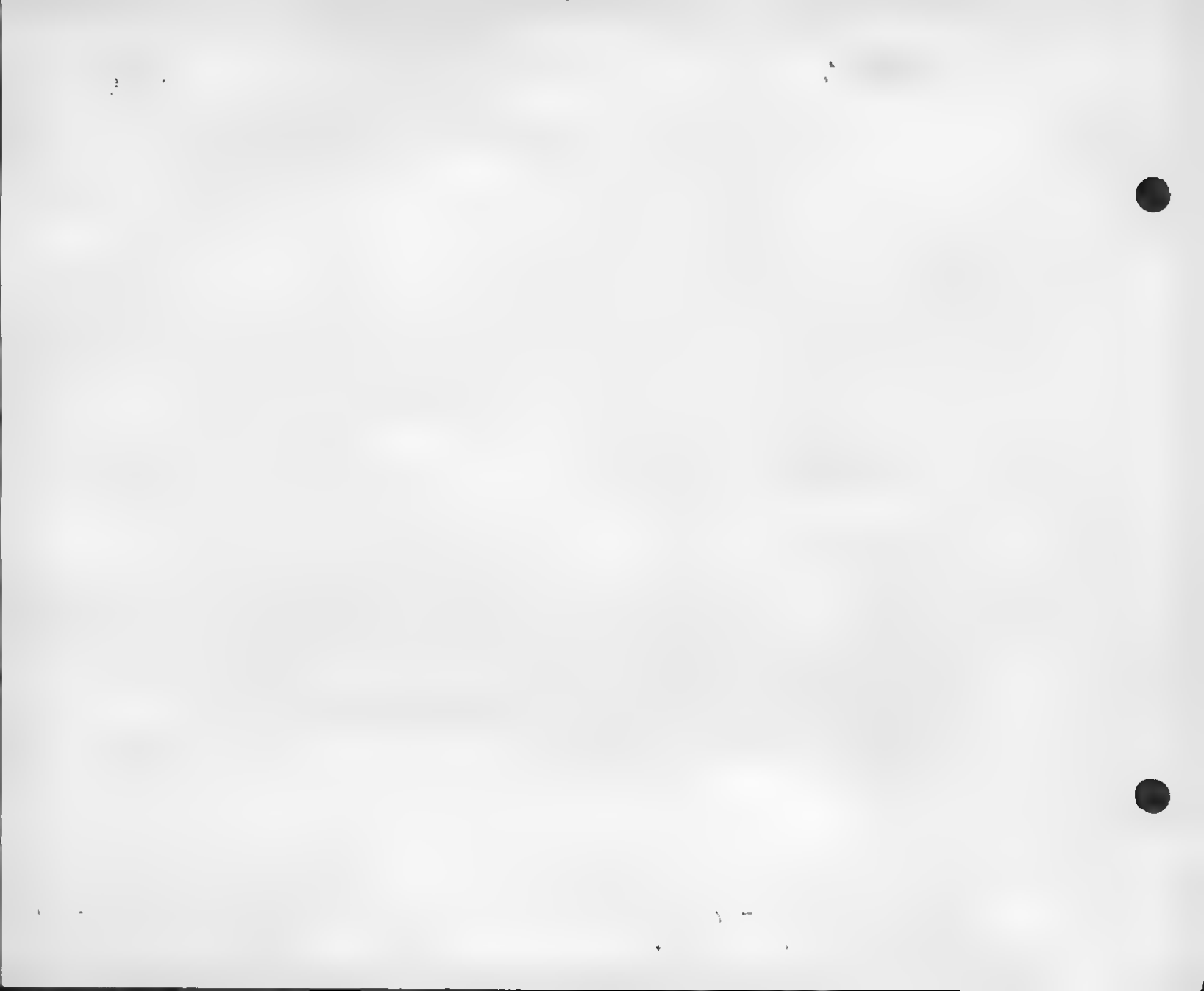
1

CERTIFICATE OF DEATH

06865

06852

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Virginia b COUNTY Westmoreland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN TB 17 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, Bethesda, Maryland		d STREET ADDRESS 805 Monroe Bay Avenue	
3 NAME OF DECEASED (Type or print) Dewey Parkinson Fletcher		4 DATE OF DEATH Month May Day 5 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 May 1958
9 AGE (In years last birthday) 8 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
10b KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State, or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Joseph J. Fletcher	
14 MOTHER'S MAIDEN NAME Helen Parkinson		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOC. SEC. NO. None		17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Toxic Hepatitis DUE TO (c) Acute Lymphocytic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 Weeks 3 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from 18 April , 19 67 , to 5 May , 19 67 , that (he) (we) last saw the deceased alive on 5 May , 19 67 , and that death occurred at 12:30 PM , from causes and on the date stated above.			
22a SIGNATURE Roland T. Skeel, MD.		22b DATE SIGNED May 5, 1967	
22c PHYSICIAN'S NAME (Type) Roland T. Skeel, MD.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF May 7-67	23c NAME OF CEMETERY OR CREMATORY Round Hill	23d LOCATION (City or Town) (County) (State) Ninde, King George Co., Va.
24 FUNERAL DIRECTOR Nash & Slaw, Ninde, Va.		25a REC'D BY REGISTRAR MAY 9 1967	25b REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06866

CERTIFICATE OF DEATH

06853

1 PLACE OF DEATH a COUNTY <u>Montgomery County</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Florida</u> b COUNTY <u>Brevard</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring, Md.</u>				c LENGTH OF STAY N 1b <u>1 yr.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <u>Colonial Villa Nursing Home</u>				d STREET ADDRESS <u>210 Norwood Ave</u>			
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Manuel</u> Last <u>Foschia, Sr.</u>				4 DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 3, 1900</u>	
9 AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>		IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Missile Specialist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>government</u>		11 BIRTH-PLACE (County & State or foreign country) <u>Udine, ITALY</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>John Foschia</u>				14 MOTHER'S MAIDEN NAME <u>Unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>263-14-0447</u>		17 INFORMANT <u>Son John, Jr.</u>		Address <u>Foschia, 18711 Rte. 5, Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1651 DUE TO (b) <u>Oat cell Carcinoma, lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>1 1/2 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), <u>Arteriosclerotic Heart Disease</u>							9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Oct. 1966</u> to <u>28 May 1967</u> that (I) (we) last saw the deceased alive on <u>24 May 1967</u> and that death occurred at <u>11:00 PM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>J. Frederick BARR</u> M.D.				22b DATE SIGNED <u>5/28/67</u>		22c PHYSICIAN'S NAME (Type) <u>J. Frederick BARR, M.D.</u>	
22d ADDRESS <u>4500 College Ave College Park, Md</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>		23b DATE THEREOF <u>May 31, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Our Lady of Mercy Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Miami, Florida</u>	
24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				25 REC'D BY REGISTRAR <u>8434 Georgia Avenue</u>		25b REGISTRAR'S SIGNATURE <u>June 2 1967</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

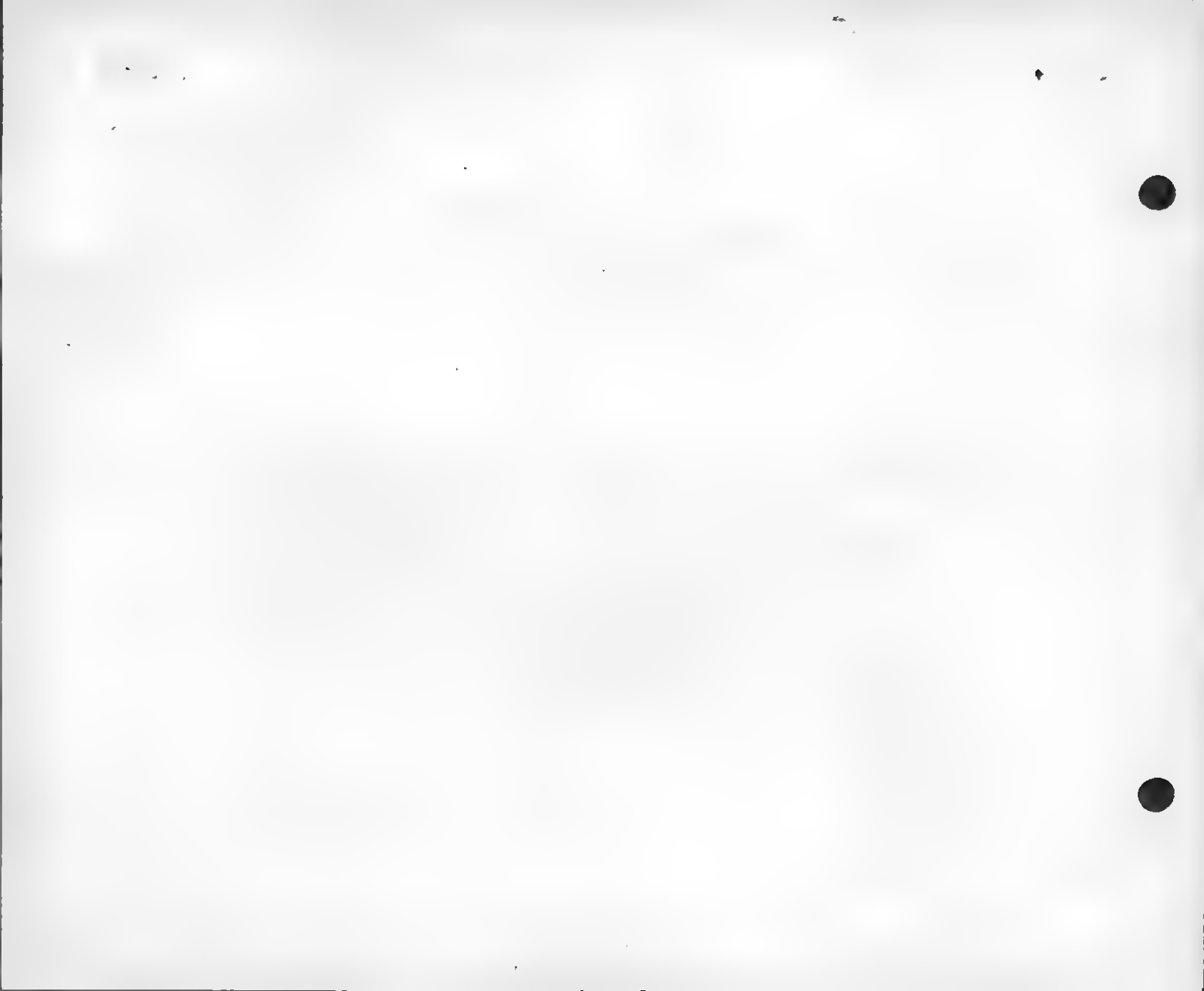
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06854

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If inside corporate limits write RURAL and give nearest town) <u>Rockville Pike</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN IL <u>L.C.A.</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>12207 Braxfield Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>12207 Braxfield Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John F. Foxier</u>		4 DATE OF DEATH <u>May 31 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-27-46</u>
9 AGE (in years, last birthday) <u>20</u> yrs		10 IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> Hours <u>0</u> Mins <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>	
12. BIRTHPLACE (State or foreign country) <u>U.S. Air Force</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
3 FATHER'S NAME <u>John F. Foxier</u>		14 MOTHER'S MAIDEN NAME <u>John F. Foxier</u>	
5 WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) (If yes give war or dates of service) <u>1964-66</u>		16 SOCIAL SECURITY NO <u>123-45-6789</u>	
17 INFORMANT <u>John F. Foxier</u>		Address <u>123-45-6789</u>	
8 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <u>1731</u> IMMEDIATE CAUSE (a) <u>Exhaust fumes of motor led into room while</u> DUE TO (b) <u>Exhaust fumes of motor led into room while</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Exhaust fumes of motor led into room while</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Exhaust fumes of motor led into room while</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:00 AM May 27 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parking Lot</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John F. Foxier</u> M.D.		22. DATE SIGNED <u>May 31 1967</u>	
EXAMINER'S NAME (Type) <u>John F. Foxier</u>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>123-45-6789</u>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>May 31 1967</u>	25b. REGISTRAR'S SIGNATURE <u>John F. Foxier</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

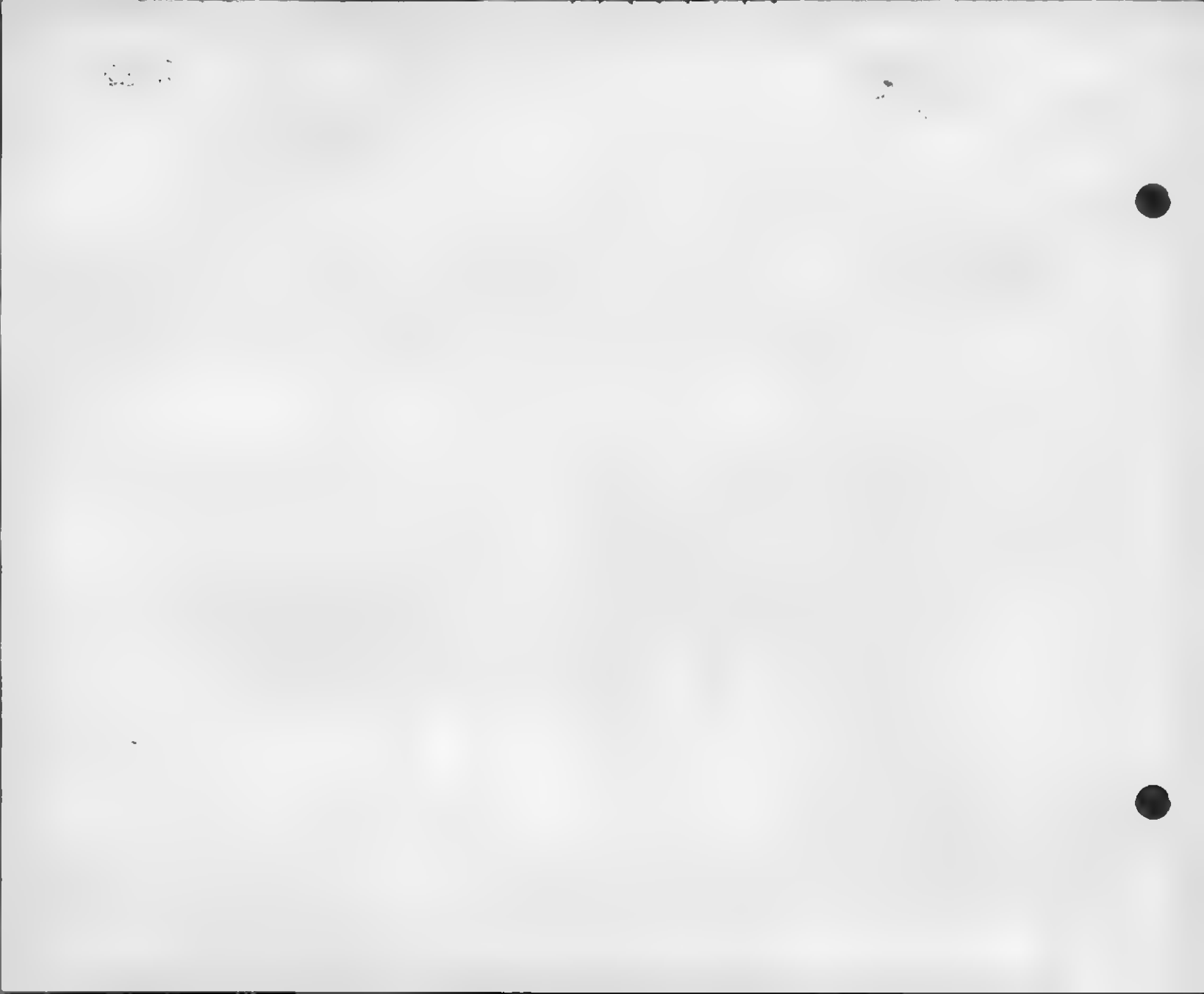
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06865

CERTIFICATE OF DEATH

06855

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Virginia b COUNTY Loudon	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY in 1b 23 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d STREET ADDRESS Route #2	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Marion O. Fulchier		4 DATE OF DEATH Month Day Year May 26 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 23 July 1895
9 AGE (in years last birthday) 71 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Agriculture	
11 BIRTHPLACE (County & State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Fulchier		14 MOTHER'S MAIDEN NAME Mollie Tibbs	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16 SOCIAL SECURITY NO Not available	
17 INFORMANT The Medical Records Center, Bethesda, Maryland 20014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 3 May 1967, to 26 May 1967, that (2) (we) last saw the deceased alive on 26 May 1967, and that death occurred at 7:22 AM from causes and on the date stated above			
22a SIGNATURE Sidney M. Wolfe, MD		22b DATE SIGNED 26 May 67	
22c PHYSICIAN'S NAME (Type) Sidney M. Wolfe, MD		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Removal - Burial	5-26-67	Chestnut Grove Cemetery, Herndon, Virginia	
24 FUNERAL DIRECTOR Green Funeral Home, Herndon, Virginia		25a REC'D BY REGISTRAR MAY 29 1967	
		25b REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06863

CERTIFICATE OF DEATH

06856

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural) c. LENGTH OF STAY IN b. 37 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CAPE ST. JOHN d. STREET ADDRESS ROUTE #1 BOX 258 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EARL Middle IVAN Last GADDIS		4. DATE OF DEATH Month MAY Day 11 Year 1967					
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 DEC 1906	9. AGE (In years last birthday) 60 yrs	F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hrs Mins		
10a. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY Rt.		11. BIRTHPLACE (County & State or foreign country) WILLIAMSON COUNTY, ILL.			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DAVE GADDIS		14. MOTHER'S MAIDEN NAME MAMIE SANDERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII-KOREA		16. SOCIAL SECURITY NO		17. INFORMANT MRS. ANNA P. GADDIS RT. #1 BOX 258 CAPE ST. JOHN ANNAPOLIS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEVERE ARTERIO SCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					9. WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4 APRIL 1967 to 11 MAY 1967 that (I) (we) last saw the deceased alive on 11 MAY 1967 , and that death occurred at 2:50 p.m. from causes and on the date stated above							
22a. SIGNATURE J. E. Davis		22b. DATE SIGNED 12 MAY 1967		22c. PHYSICIAN'S NAME (Type) J. E. DAVIS			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-16-67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VA			
24. FUNERAL DIRECTOR JOHN M TAYLOR FUNERAL HOME		25. REC'D BY REGISTRAR 147-149 GLOUCESTER ANNAPOLIS, MD.		25b. DATE MAY 15 1967			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate writing the ward pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (B)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06870

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06857

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in Md. Re. given before admission) a STATE <u>Maryland</u> b TOWNSHIP <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write R.U.R. and give nearest town) <u>Damascus</u>		c LENGTH OF STAY IN MD <u>Damascus</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>27608 Ridge Rd</u>		d STREET ADDRESS <u>27608 Ridge Rd</u>	
3 NAME OF DECEASED (Type or print) <u>ELVET W. GAITHER</u>		4 DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-20-1910</u>
9 AGE (in years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HR. Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Laborer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Cement</u>	
11 8 RTH. PLACE (State or foreign country) <u>Damascus</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas E. Gaither</u>		14 MOTHER'S MAIDEN NAME <u>Alice Welsh</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>216-03-6636</u>	
17 INFORMANT <u>Preston B. Gaither, Damascus, Md.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Ethylism; Pulmonary T.B. (Active)</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>5/28/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (City, town, county) <u>Damascus, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 29, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Friendship</u>	23d LOCATION (City or town) (County) (State) <u>Damascus, Md.</u>
24 FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a RECD BY REG STRA... 1967 DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06871

06858

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived for 1 year or more before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If not in corporate limits write RURAL and give nearest town) <u>Olney</u>		c LENGTH OF STAY IN b <u>8 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Montgomery General Hospt.</u>		d STREET ADDRESS <u>Rt. 3</u>	
3 NAME OF DECEASED (Type or print) <u>ACNES ELLI GARRETT</u>		4 DATE OF DEATH <u>5 27 19 67</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-26-78</u>
9 AGE (In years, months, and days) <u>39 yrs</u>		10 FINDER YEAR <u>19 67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Buck Sparrow</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Briggs</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>577-26-9976</u>	
17 INFORMANT <u>Medical Records of Montr. General Hospt.</u>		18 ADDRESS <u>Olney, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Pulmonary Infarct, lcf</u> (b) <u>lower lobe; Bronchopneumonia, bilateral</u> (c) <u>Arteriosclerotic Heart Disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONNOTION GIVEN IN PART I (a) 20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Deceased fell while visiting in Florida on 17, 1967 + fractured right hip</u> 20c TIME OF INJURY Month, Day, year <u>5-17-1967</u> Hour a.m. <u>5</u> p.m. <u>17</u> 20d NATURE OF INJURY <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u> 20f (City or town) <u>Lima, Ohio</u> (County) <u>Lima</u> (State) <u>Ohio</u>			
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. Elden R. Heap</u> M.D.		22. DATE SIGNED <u>5/28/1967</u>	
EXAMINER'S NAME (Type) <u>J. Elden R. Heap</u>		23a BURIAL, CREMATION, REMOVAL (Specify) <u>5-31-67</u>	
23b DATE THEREOF <u>5-31-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	
23d LOCATION (City or town) <u>Gaithersburg</u> (County) <u>Montg.</u> (State) <u>M.D.</u>		24 FUNERAL DIRECTOR <u>Ernest C. Galtner</u> ADDRESS <u>One</u>	
25a REC'D BY REG. STAMP <u>MAY 31 1967</u>		25b REG. STAMP'S SIGNATURE <u>J. Elden R. Heap</u>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06872

CERTIFICATE OF DEATH

06859

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Wash. D.C.</u> b COUNTY <u>Wash. D.C.</u>	
b CITY OR TOWN (If out of corporate limits write RURAL and give nearest town)		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth. - Silver Spring Nurs. Home</u> <u>8700 Jones Mill Rd. Beth. Md.</u>		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Minnie Gensberg</u>		4 DATE OF DEATH <u>May 15 1967</u>	
e SEX <u>F</u>	f COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-30-1914</u>
9 AGE (In years last birthday) <u>52</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
13 FATHER'S NAME <u>ISRAEL FINEBURG</u>		14 MOTHER'S MAIDEN NAME <u>HANNAH</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Son</u>		Address <u>4201 Cathedral Ave. NW</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>5/15</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>5/12</u> , 19 <u>67</u> , and that death occurred at <u>8:45</u> A.M., from causes and on the date stated above.			
22a SIGNATURE <u>G. Lennard Gold</u>		22b DATE SIGNED <u>5/15/67</u>	
22c PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>		22d ADDRESS <u>8641 Colesville Rd. Sil. Sp. Md.</u>	
23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE THEREOF <u>5/17/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washingt. D.C.</u>
24 FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25a REG'D BY REGISTRAR <u>MAY 18 1967</u>	
ADDRESS <u>3501-14th St. NW, Wash. DC</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camp detached in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

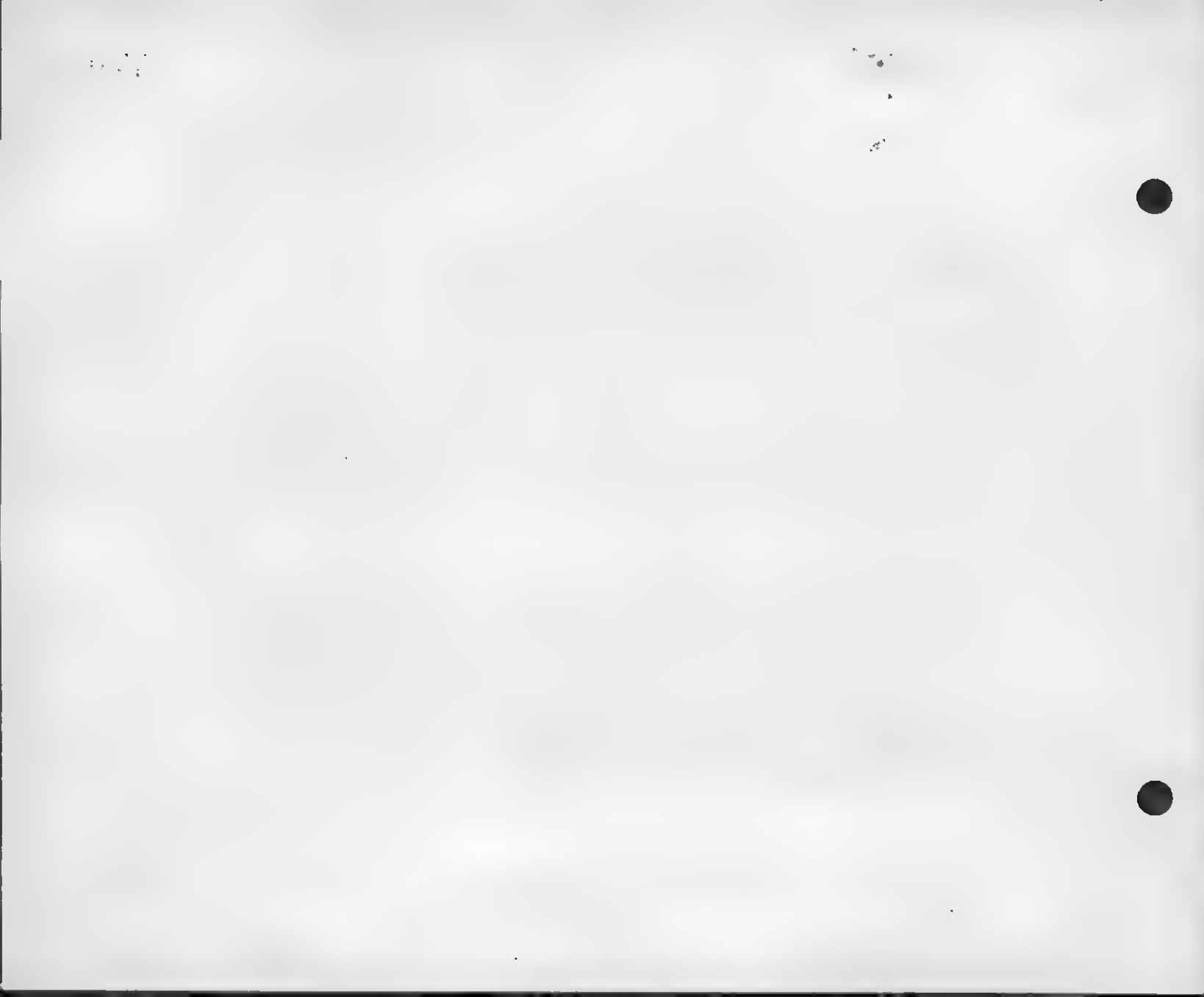
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06873

CERTIFICATE OF DEATH

06860

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 23 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014			d STREET ADDRESS 5819 Maryhurst Drive		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Linda Marie Gentilcore			4 DATE OF DEATH Month Day Year May 1 19 67		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1 July 1951	9 AGE (In years last birthday) 15 yrs	10 IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR OCCUPATION SCHOOL		11 BIRTHPLACE (County & State or foreign country) Washington, D.C.	
12 CITIZENSHIP OF WHAT COUNTRY? USA			13 FATHER'S NAME Phil A. Gentilcore		
14 MOTHER'S MAIDEN NAME Viola D'Amico			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16 SOCIAL SECURITY NO None			17 INFORMANT The Medical Record The Clinical Center, Bethesda, Maryland 20014		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO (b) Acute lymphocytic leukemia DUE TO (c) Generalized Mucous Membrane hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 4 days 3 1/2 years 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Toxic hepatitis					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21 I certify that (X) (this hospital) attended the deceased from April 8, 19 67, to May 1, 1967, that (X) (we) last saw the deceased alive on May 1, 19 67, and that death occurred at 3:30 M, from causes and on the date stated above					
22a SIGNATURE Jerry L. Spivak			22b DATE SIGNED P. 1 May 1967		22c PHYSICIAN'S NAME (Type) Jerry L. Spivak, MD
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE THEREOF 5/5/67		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet
24 FUNERAL DIRECTOR Francis Gasch's Sons			ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DATE MAY 5 1967
25b REGISTRAR'S SIGNATURE Charles Judge			25c REGISTRAR'S SIGNATURE		



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08357

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first where residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>7404 Pyle Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Michael</u> First <u>Gerety</u> Middle Last		4 DATE OF DEATH <u>May 31 1967</u> Month Day Year	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/4/43</u> 9. AGE (in years last birthday) <u>23</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James P. Gerety</u>	
14. MOTHER'S MAIDEN NAME <u>Kathleen Corbett</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>James P. Gerety</u> Address <u>---</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>7531</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Idiopathic seizures and mental retardation</u> DUE TO (c) <u>Congenital brain disease of undetermined etiology</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			19. WA AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____, _____, State, _____
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on <u>5/31</u> 19 <u>67</u> , and that death occurred at <u>7:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph J. Brennan</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Joseph J. Brennan</u>		22d. ADDRESS <u>Cherry Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-2-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery/ Silver Spring, Md.</u>	23d. LOCATION (City or town) _____, _____, (State) _____
24. FUNERAL DIRECTOR <u>Joseph Cowler's Sons, Inc.</u> ADDRESS <u>3130 Wisc. Ave. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>---</u>	

4.

3. 2. 1. 0. 1. 2. 3.



1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>VIRGINIA</u>		b COUNTY <u>FAIRFAX</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN IB <u>47 days 16 hrs.</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				d STREET ADDRESS <u>2724 Chain Bridge Rd.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First Middle Last <u>MARGARET ANN GREEN</u>		4 DATE OF DEATH Month Day Year <u>MAY 19 1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-28-94</u>		9 AGE (In years last birthday) <u>72 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>VA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13 FATHER'S NAME <u>NORMAN MATHERS</u>				14 MOTHER'S MAIDEN NAME <u>Laura Thomas</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>2</u>		17 INFORMANT <u>H. S. McLENNAN, Int 10 Park St.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per item for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Symptomatic Sarcoma</u> <u>20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WA-AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home farm factory street office building etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>67</u> to <u>5/20/67</u> , that (II) (we) last saw the deceased alive on <u>5/19</u> 19 <u>67</u> , and that death occurred <u>12:30 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>[Signature]</u>		MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <u>5/20/67</u>	
22b PHYSICIAN'S NAME (Type)		22d ADDRESS					
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE THEREOF <u>5/24/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Flint Hill</u>		23d LOCATION (City or town) (County) (State) <u>Arlington Fairfax Co VA</u>	
24 FUNERAL DIRECTOR <u>White & King Funeral Home, Arlington Co.</u>				25a REC'D BY REGISTRAR <u>[Signature]</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	
				DATE <u>MAY 23 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

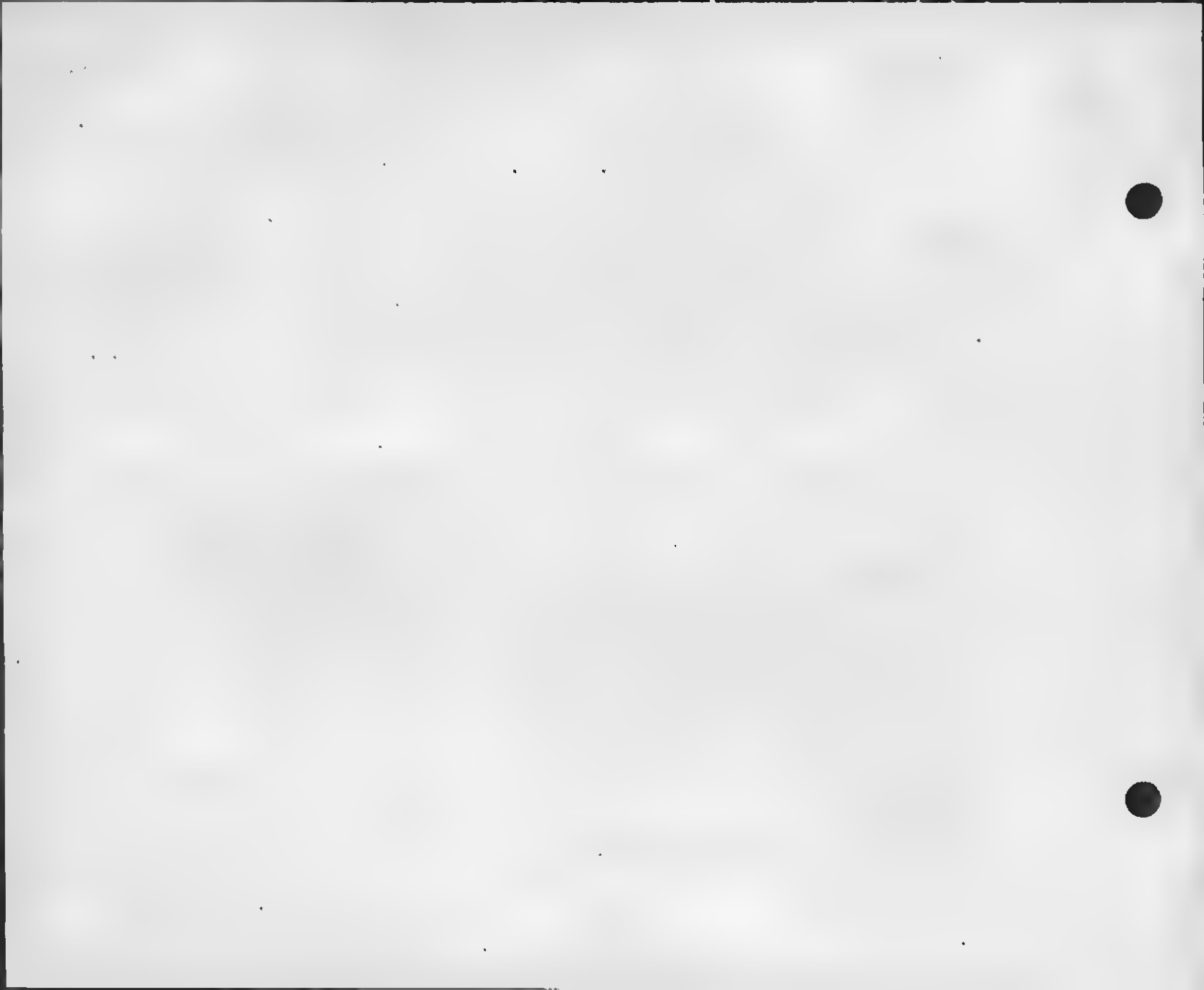
CERTIFICATE OF DEATH

06876

06862

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 15				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Rosario Giovanni</i>				4. DATE OF DEATH Month Day Year <i>May 25 1967</i>									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years) IF UNDER 1 YEAR last birthday Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Giannantonio</i>						14. MOTHER'S MAIDEN NAME <i>Antonio Giannantonio</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prophageic Cocciemia with disseminated metastases + secondary anemia</i> DUE TO (b) <i>disseminated metastases +</i> DUE TO (c) <i>secondary anemia</i> PART II. OTHER SIGNIF. COND. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1966</i> to <i>May 26 1967</i> , that (I) (we) last saw the deceased alive on <i>May 25 1967</i> , and that death occurred at <i>1:15</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Boris Rabin</i>				22b. DATE SIGNED <i>5/26/67</i>									
22c. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN</i>				22d. ADDRESS <i>1019 University Blvd E 55</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR				ADDRESS				25a. RECD BY REGISTRAR <i>MAY 31 1967</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the circumstances in writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the coroner. Pages 4, 5, and 6 may be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

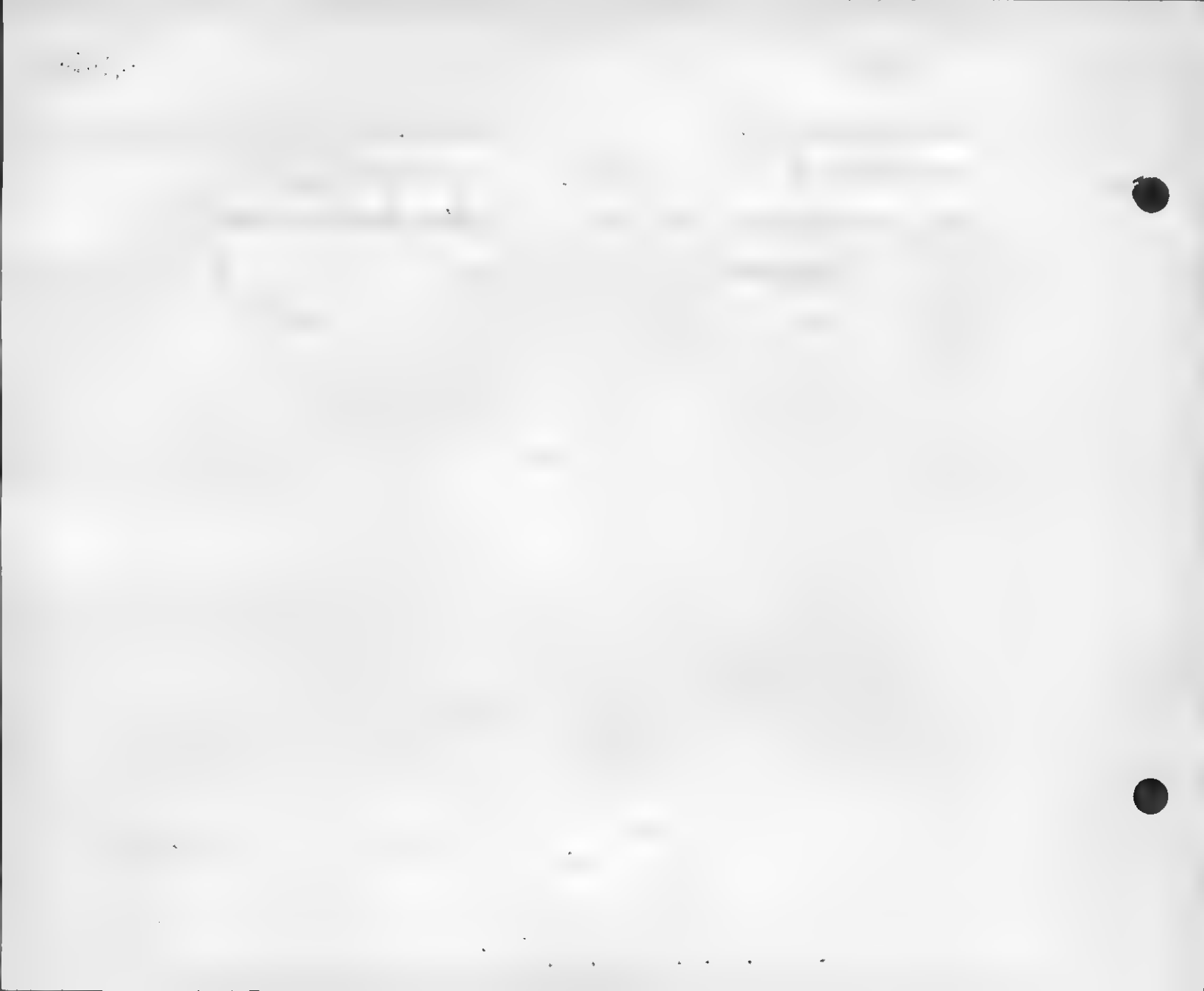
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06863

1 DECEASED COUNTY <u>Montgomery</u> <u>Beckford</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <u>Montford Montgomery</u> <u>Beckford</u>	
3 LENGTH OF STAY IN 1b <u>DOA</u>		4 DATE OF DEATH <u>5-27-67</u>	
5 NAME OF DECEASED (Type or print) <u>Lynwood O. Gibson</u>		6 DATE OF BIRTH <u>10-29-1904</u>	
7 SEX <u>M</u>		8 AGE <u>62</u>	
9 MARRIED <u>W</u>		10 IF UNDER 1 YEAR <u>Months</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator</u>		12 BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13 FATHER'S NAME <u>HUGH R. Gibson</u>		14 MOTHER'S MAIDEN NAME <u>Pearl Kirby</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16 SOCIAL SECURITY NO. <u>577-05-4356</u>	
17 INFORMANT <u>Clara Jo Gibson</u>		18 ADDRESS <u>See Item #2</u>	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery heart</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
20 PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE OF DEATH <u>---</u>		21 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		22b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>---</u>	
22c TIME OF INJURY Month, Day, Year <u>9</u>		22d PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
23 I certify that I took charge of the deceased and have taken care of the body and death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24 CHIEF MEDICAL EXAMINER <u>Belden R. Reap</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Wheaton</u>	
25 ACTUAL SIGNATURE <u>Belden R. Reap</u>		26 DATE SIGNED <u>5/28/1967</u>	
27 EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		28 BURIAL CREMATION <u>Removal</u>	
29 DATE THEREOF <u>5-31-1967</u>		30 NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
31 LOCATION (City or town) (County) (State) <u>Raleigh, Miss.</u>		32 FUNERAL HOME FOR <u>Joseph Jewler's Sons, Inc.</u>	
33 ADDRESS <u>1170 Wisc. Ave. Wash. DC.</u>		34 DATE <u>MAY 31 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06878

06864

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or residence for less than 1 year) a STATE <u>MONTGOMERY</u> COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Montgomery General Hospital</u>		d STREET ADDRESS <u>Box 90B Oxley Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ambrose</u> Middle <u>Norman</u> Last <u>Gipe</u>		4 DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 1, 1913</u>
9 AGE (In years, last birthday) <u>53</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machineist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Tool & Die Co. Ill.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harry Gipe</u>		14 MOTHER'S MAIDEN NAME <u>Gertrude Curry</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>139-14-1510</u>	
17 INFORMANT <u>Montgomery Gen. Hospital</u>		Address <u>Olney, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral + liver metastasis</u> 10 = X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Squamous cell carcinoma of lung + Pleura</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19 WA. A POSTMORTEM PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u> </u> , 19 <u> </u> , that (I) (we) just saw the deceased alive on <u>5-2</u> 19 <u>67</u> , and that death occurred at <u>6:45 am</u> from causes and on the date stated above.			
22a SIGNATURE <u>L. S. Batman</u> M.D.		22b DATE SIGNED <u>5-2-67</u>	
22c PHYSICIAN'S NAME (Type) <u>L. S. Batman, M.D.</u>		22d ADDRESS <u>Damascus, Md.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 4, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u>	23d LOCATION (City or town) (County) (State) <u>Clagettville, Md.</u>
24 FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a REC'D BY REGISTRAR <u>MAY 4 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute a "pre-death" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

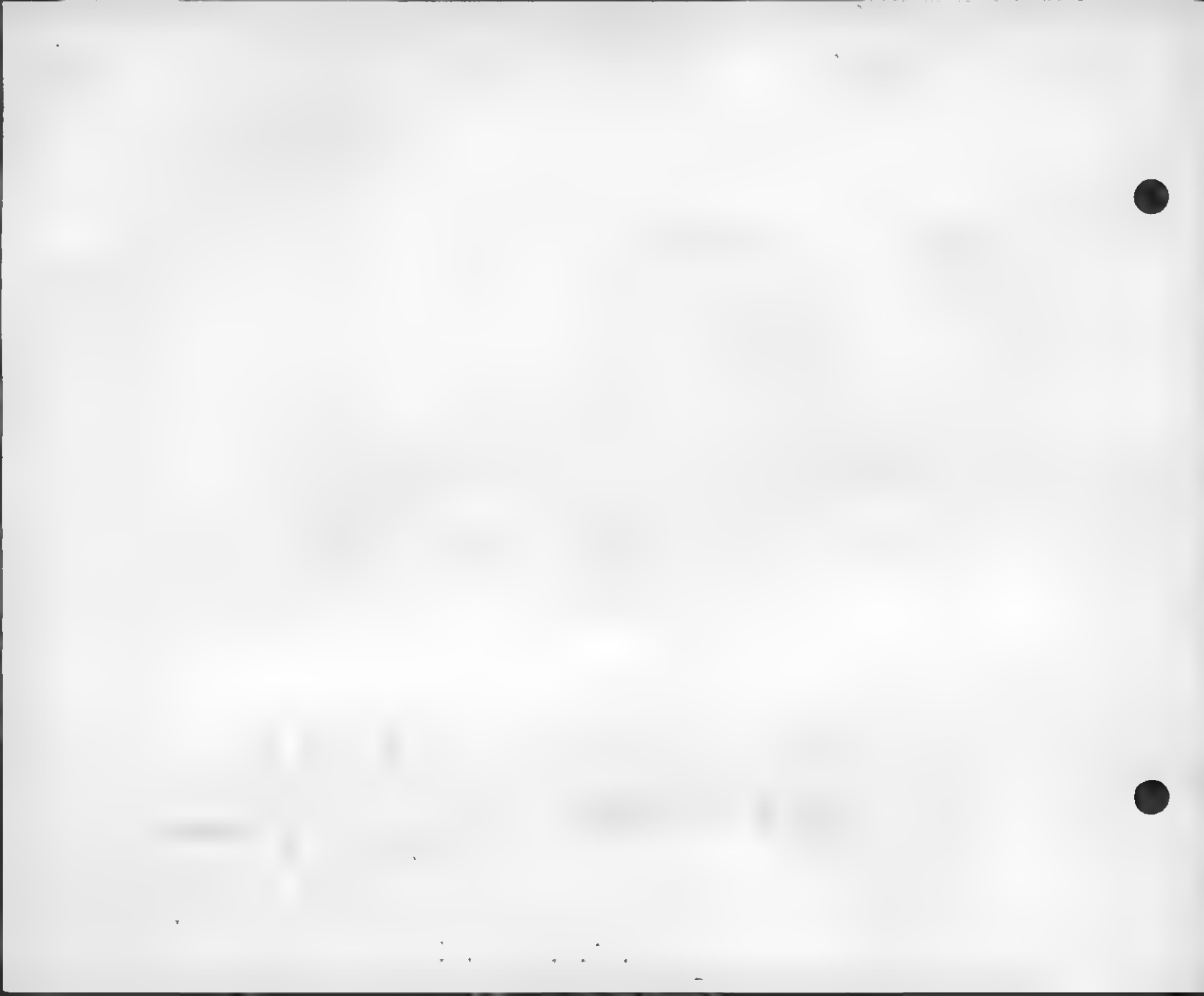
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06873

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06865

1 PLACE OF DEATH a COUNTY <u>ALLEGANY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) 1 institution 2 residence before admission a STATE <u>MD</u> b COUNTY <u>ALLEGANY</u>	
b CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>WHEELING</u>		c LENGTH OF STAY IN TB <u>2 wks</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WHEELING HOSPITAL</u>		d STREET ADDRESS <u>1000 11th St</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Ball</u> Last <u>Ball</u>		4 DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-12-1905</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>USA</u>		12 COUNTRY OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>John F. Ball</u>		14 MOTHER'S MAIDEN NAME <u>Rose Ball</u>	
15 WAS DECEASED EVER IN ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>3-10-7-5411</u>	
17 INFORMANT <u>John Ball</u>		Address <u>1000 11th St</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u> DUE TO <u>coronary arteriosclerosis, severe</u> (b) <u>None</u> DUE TO <u>None</u> (c) <u>None</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, Part I, Part II, etc.) <u>None</u>		20c PLACE OF INJURY <u>Home</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unnatural and manner <input type="checkbox"/>		22 DATE SIGNED <u>5/25/67</u>	
ACTUAL SIGNATURE <u>John E. Ball</u> M.D.		CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	
23 BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>5-29-1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d LOCATION (City, County, State) <u>Suitland, Md.</u>	
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>		25 SIGNED BY REGISTRAR <u>John E. Ball</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06880

05866

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>32 Hickory Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>32 Hickory Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>H</u> Last <u>GONTER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29 1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Govt. Serv.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas S. Gonter</u>				14. MOTHER'S MAIDEN NAME <u>Alice Clark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William E. Gonter</u> Address <u>(same as #2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>arterio-sclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 8, 1967</u> , to <u>May 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. B. Little</u>				22b. DATE SIGNED <u>May 8 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>	
22d. ADDRESS <u>6911 5th St. NW, Wash. D.C.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	
23d. LOCATION (City, town or county) <u>Washington D.C.</u>		23e. FUNERAL DIRECTOR <u>Arthur Walton</u>		23f. ADDRESS <u>254 Carroll St. NW, D.C.</u>		23g. REC'D BY REGISTRAR <u>Charles Judge</u>	
23h. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23i. DATE <u>MAY 12 1967</u>		23j. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23k. DATE <u>MAY 12 1967</u>	



TO DEPUTY MEDICAL EXAMINER:

5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Death certificate should be executed within 24 hours after death. If delay, within the word "pending" in item 18. Give Pages 1, 2 and 3 to the Chief Medical Examiner's Office along with form 90. Page

FOR STATE HEALTH DEPT.

Items 10&21 0-5-67 389

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W PRESTON STREET, BALTIMORE MARYLAND 21201

06881

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06867

1 PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>REAR HILLSIDE MOTORS - HUNGERFORD DRIVE</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NO FIXED ADDRESS</u> d STREET ADDRESS	
3 NAME OF DECEASED First <u>JESSE</u> Middle <u>WILBUR</u> Last <u>GOSSARD</u> Sex <u>MALE</u> <u>WHITE</u> b 10 OR OR RAC 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>JAN 22/1899</u> 9 AGE <u>68</u> years Month <u>MAY</u> Day <u>19</u> Year <u>67</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>PENNA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>?</u>		14 MOTHER'S MAIDEN NAME <u>VIOLA MEYERS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>218-16-2144</u>	
17 INFORMANT <u>JOHN</u> <u>RAYMOND GOSSARD - HYATTSVILLE, MD.</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatty metamorphosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO (b) <u>Acute & chronic alcoholism</u> (c)	
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the report described above, held an Autopsy <input checked="" type="checkbox"/> death after from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John G. Ball</u> John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/14/67</u> Address (Street, city, town or county)	
VAL (Specify) <u>5-17-67</u> <u>James G. Gartner, Gaithersburg, Md.</u> <u>MAY 17 1967</u> <u>John G. Ball</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06882

CERTIFICATE OF DEATH

06868

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Michigan</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>115 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grand Rapids</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>226 Franklin Street, S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <u>Spencer Leland Gregory</u>			4 DATE OF DEATH Month Day Year <u>May 8 1967</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 July 1934</u>		9 AGE (in years last birthday) <u>32</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YMCA</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13 FATHER'S NAME <u>Spencer Gregory</u>			14 MOTHER'S MAIDEN NAME <u>Mary Lindsay</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>228-28-8913</u>		17 INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Septicemia</u> DUE TO (b) <u>Bone Marrow Aplasia</u> DUE TO (c) <u>Generalized Lymphosarcoma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>0 Weeks</u> <u>10 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan 13, 1967</u> , to <u>May 8, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>2:35 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Leroy Fasse</u>		MD. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leroy Fasse, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>5/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State) <u>WHEELING WEST VA.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1820 9TH ST. N.W. WASHINGTON, D.C.</u>		25a. RECD BY REGISTRAR <u>MAY 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



06883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06869

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		2 USUAL RESIDENCE (Where deceased resided for 1 year or more) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3 NAME OF DECEASED (Type or print) <u>Christopher</u>		4 DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-6-67</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>Washington, D.C. USA</u>
13 FATHER'S NAME <u>John Grimm</u>		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT Address
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute primary interstitial pneumonitis</u> 472 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) lost } DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. pm <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work hot While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>May 7, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		23a NAME OF CLERGY OR CREMATORY <u>MT. Olivet</u>	
23b DATE THEREOF <u>5-9-67</u>		23c LOCATION (City or town) (County) (State) <u>Wash. D.C.</u>	
24 FUNERAL DIRECTOR <u>HANLON Funeral Home</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4748 Wisconsin Ave., D.C.</u>		DATE <u>MAY 11 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is caused by the physician, the delay should be stated in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06870

06884

PLACE OF DEATH
a. COUNTY

b. RURAL (write name of nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if in hospital, give street address)

MARYLAND

USUAL RESIDENCE
a. STATE

b. COUNTY

c. CITY OR TOWN

STREET

ON A FARM?

3. NAME OF DECEASED
YD

SZCZEPAN

J. GRZESZCZYK

4. DATE OF DEATH

Month

Day

Year

SEX

White

MARRIED

☒

NEVER MARRIED

☐

DATE OF BIRTH

12/25/01

9. AGE

Year

Month

Day

Year

Month

Day

Year

Month

Day

Year

10. OCCUPATION (work or profession)

11. KIND OF BUSINESS OR INDUSTRY

12. PLACE OF BIRTH (State or country)

13. OF WHAT COUNTRY

FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. DECEASED EVER A FARMER OR WORKER IN AGRICULTURE (If yes, give words, dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

18. ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH CAUSED BY IMMEDIATE CAUSE TO

DUE TO

(Condition, if any, which gave rise to immediate cause (a) or (b) or (c))

DUE TO

PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.

20d. INJURY OCCURRED While ☐ Not While ☐ at work of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the body and in my opinion death resulted from: Normal ☐ Accidental ☐ Suicide ☐ and in my opinion

ACTUAL SIGNATURE

EXAMINER'S NAME

JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐

AN M.D. A MEMBER ☐

OF THE M.D. SOCIETY OF MARYLAND ☒

22. DATE SIGNED

5/5/67 Bethesda, Md.

Burial

5-7-67

St Peters & Paul

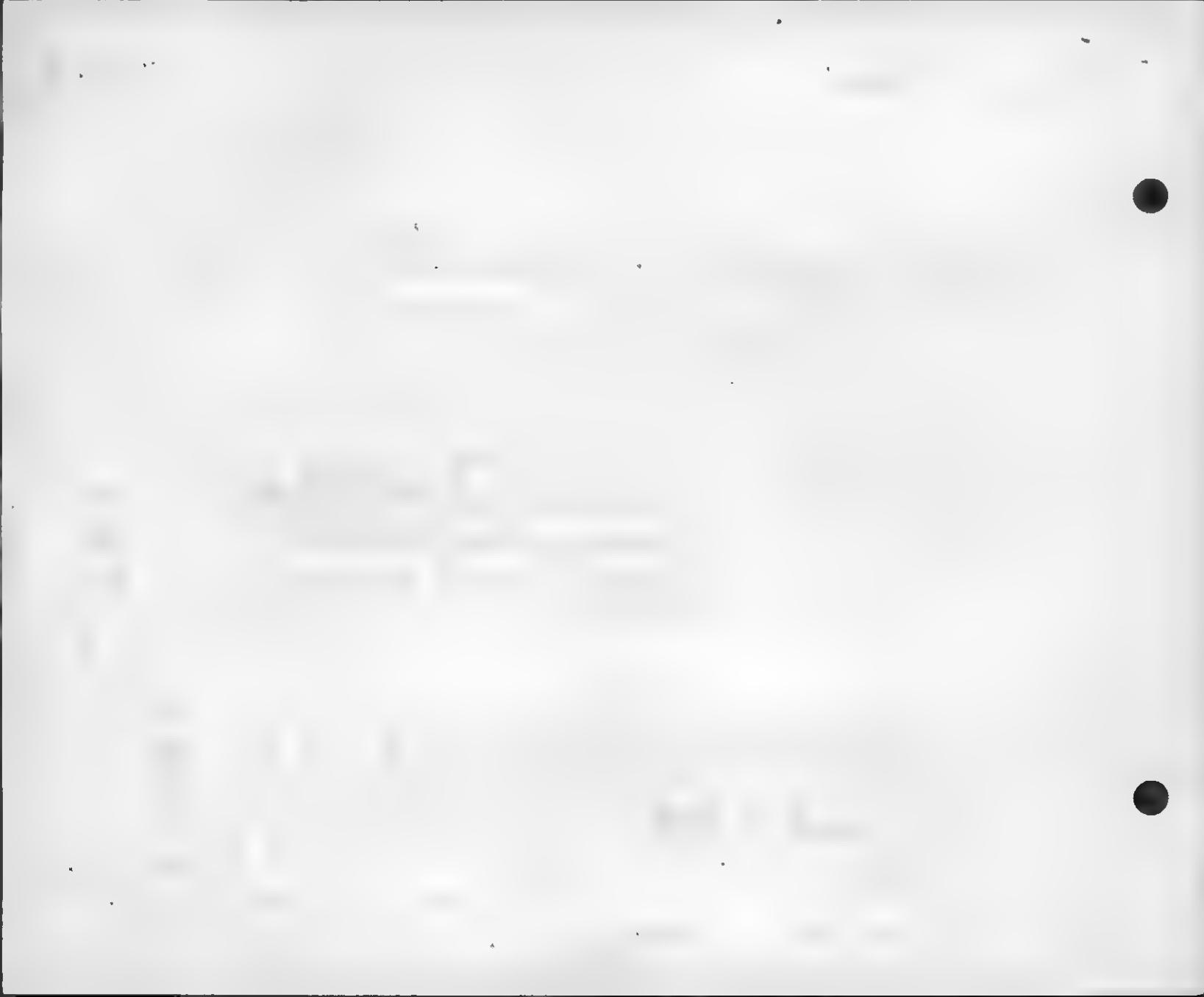
Broomall Pa Dela. Pa

24. Robert A Pumphrey 7557 Wisc Ave. Bethesda, Md

MAY 9

1967

John Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary. It may be filled out at any time within 18 days after death. Give Page 1 of 2 to the State Health Department. The original of this certificate should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. This certificate is not valid unless it is signed by the Medical Examiner. It may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be filled out as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

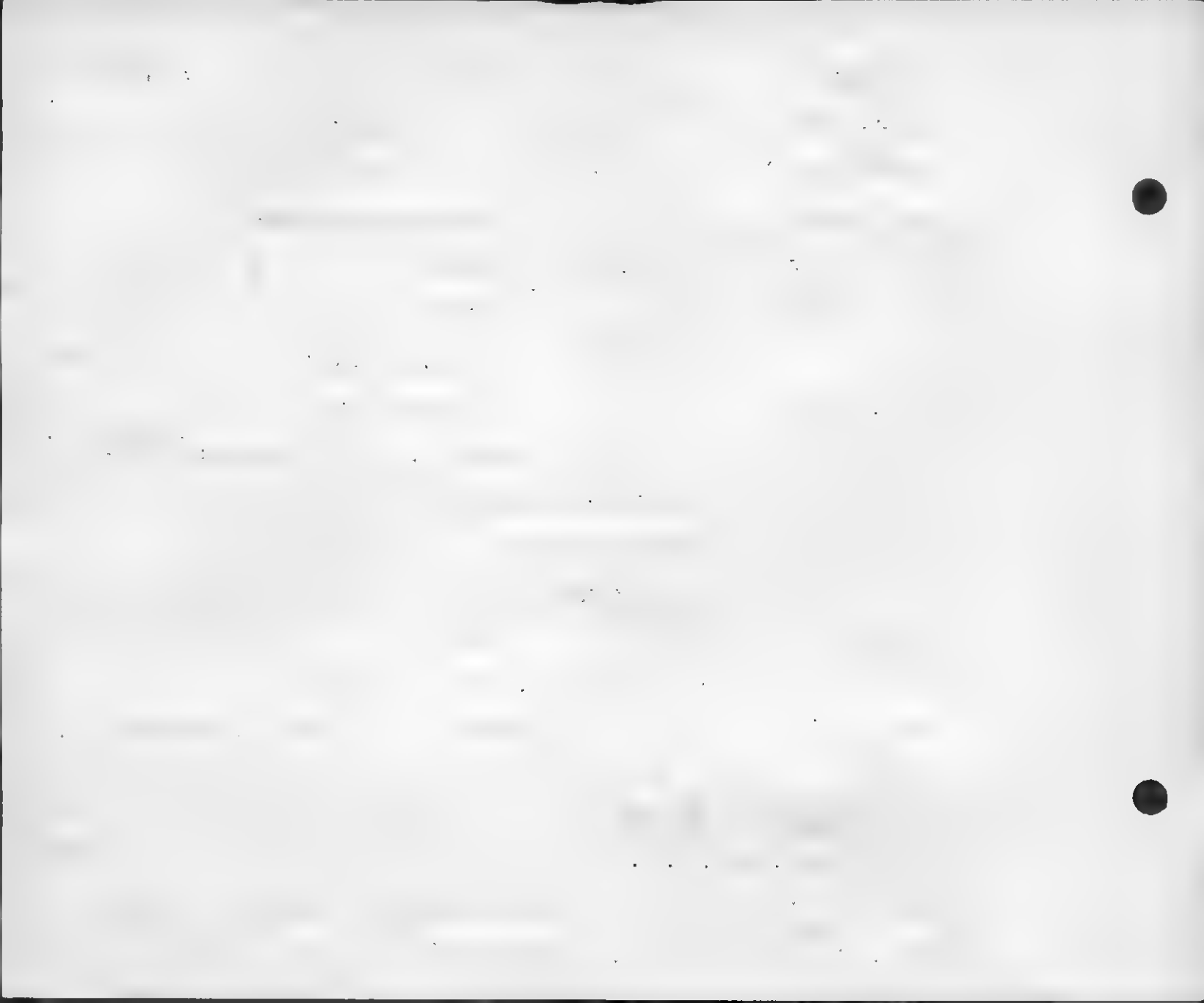
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06885

06871

PLACE OF DEATH a. COUNTY Montgomery		b. STATE Maryland		c. COUNTY	
d. CITY OR TOWN Bethesda (rural)		e. CITY OR TOWN Wheaton		f. RURAL	
g. NAME OF HOSPITAL OR INSTITUTION Naval Hospital		h. STREET ADDRESS 12822 Epping Terrace		i. R. (IDENTIFY ON A FARM) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
j. NAME OF DECEASED First Middle Last John Robert GULDE		k. DATE OF DEATH Month Day Year May 13 1967		l. AGE Year Month Day 1 1 1	
m. SEX Male		n. COLOR OR RACE Cauc		o. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
p. DATE OF BIRTH June 17, 1965		q. BIRTHPLACE (State, city, and country) Cleveland, Ohio		r. COUNTRY OF WHAT COUNTRY? USA	
s. FATHER'S NAME Robert E. Gulde		t. MOTHER'S MAIDEN NAME Doris Smith		u. ADDRESS Wheaton, Md.	
v. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) N/A		w. SOCIAL SECURITY NO. N/A		x. INFORMANT Robert E. Gulde, 12822 Epping Terrace	
y. CAUSE OF DEATH (Enter only one cause per line for Part I and Part II) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral edema DUE TO (b) Subdural hematoma DUE TO (c) Head injury		z. ONSET AND DEATH 2 days 2 days 2 days		aa. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ab. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Enter in Part II of item 18)					
ac. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> a. 7L35		ad. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell out of bed, landed on head			
ae. TIME OF DEATH Hour Minute Day Month Year 7:35 5/11 1967		af. PLACE OF INJURY While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home		ag. ADDRESS OF PLACE OF INJURY Factory, street, office bldg., etc.) Wheaton, Montgomery Md.	
ah. I certify that I took charge of the deceased described above and that the death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unnatural <input type="checkbox"/>		ai. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		aj. DATE SIGNED 13 May 1967	
ak. ACTUAL SIGNATURE EXAMINER'S NAME John G. Ball, M. D.		al. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
am. Burial 15 May 1967		an. Llano Estacado Cemetery		ao. Amarillo Texas	
ap. R. Road, Suitland, Maryland		aq. Robert E. Wilhelm Funeral Home, 4308 Suitland			

MAY 16 1967 *John G. Ball*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

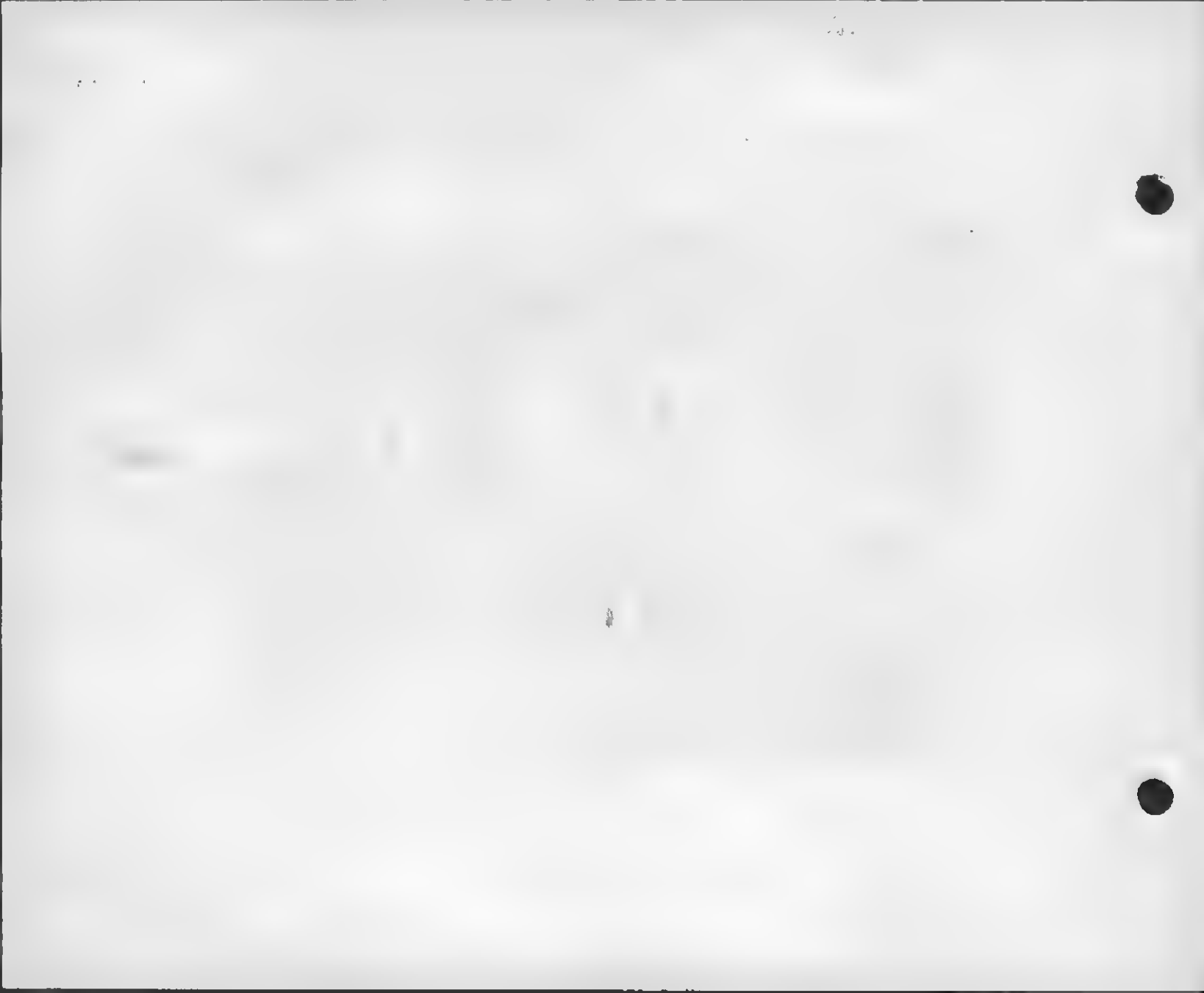
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06886

CERTIFICATE OF DEATH

06872

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BT #1 Clarksburg</u>	
c LENGTH OF STAY IN 1b <u>19 hr 30 min</u>		d STREET ADDRESS <u>BT #1, Box 1174</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Thomas Vincent Gurski</u>		4 DATE OF DEATH <u>May 21 1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/20/67</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>17</u> Months <u>30</u>
11 BIRTHPLACE (County & State or foreign country) <u>Montgomery Co, Md</u>		12 COUNTRY OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Thomas R Gurski</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Quinn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Thomas R. Gurski</u>		Address <u>Clarksburg, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interventricular subarachnoid hemorrhage</u> DUE TO (b) <u>Prominence</u> DUE TO (c) <u>juvenile arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:57</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Gary Brecker</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>3/29/67</u>	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>Thomas R. Gurski</u>		25a REC'D BY REGISTRAR	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
DATE <u>MAY 29 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

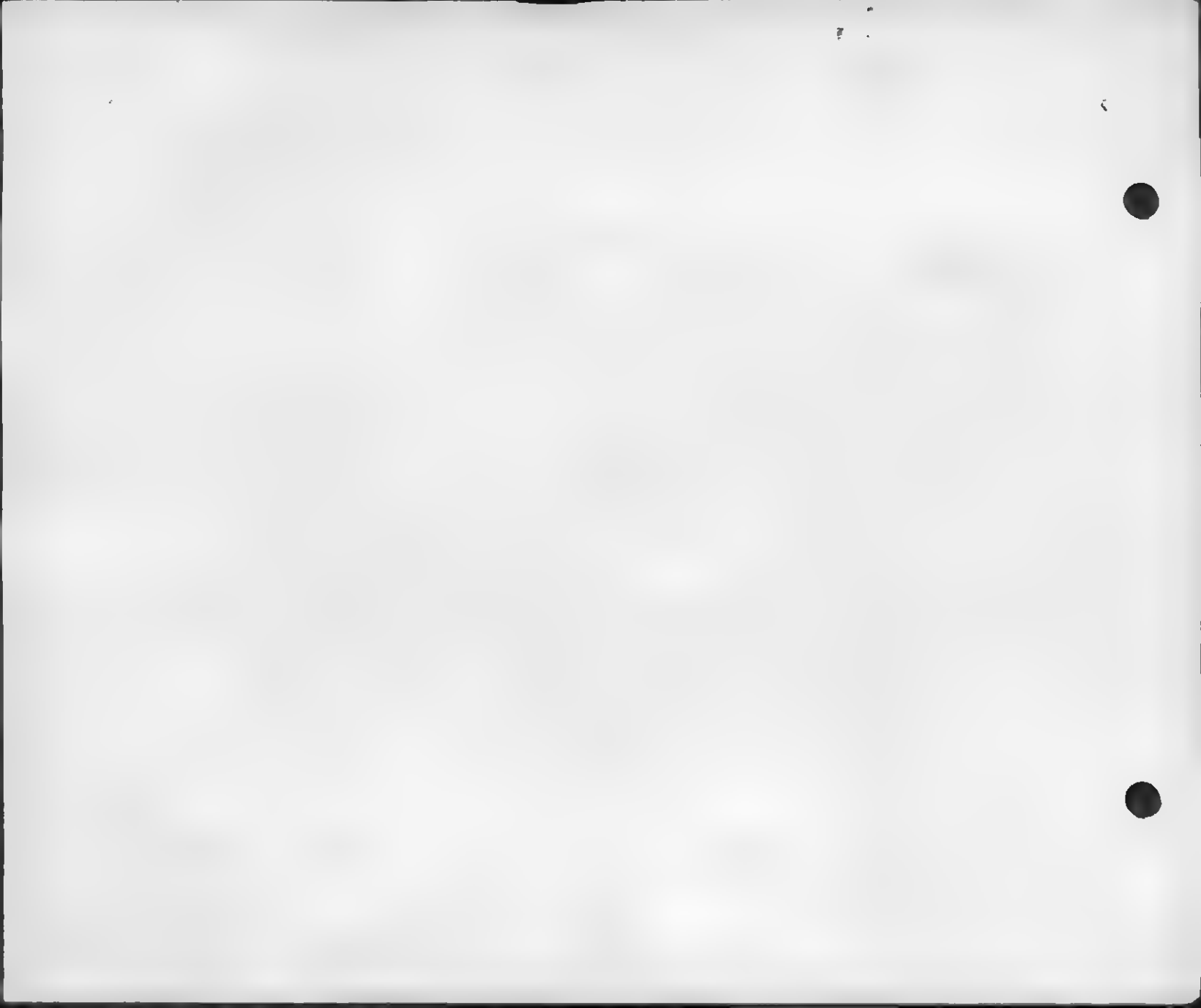
06888

06874

1 PLACE OF DEATH a. COUNTY <u>Maryland</u>		2 USUAL RESIDENCE (Where deceased lived) f. institution Res dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	c. CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>27911 Montgomeryst. Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Frank W.</u> Middle <u>F</u> Last <u>Hawn</u>		4 DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 CO. OR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/1/1900</u>
9 AGE (in year last birthday) <u>67</u> yrs		IF UNDER 12 Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Health Service</u>	11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>FRANK W. HAWN</u>	
14 MOTHER'S MAIDEN NAME <u>Constance Jones</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes give war or dates of serv ice) <u>no</u>	
16 SOCIAL SECURITY NO <u>414-50-9749</u>		17 INFORMANT <u>Frank W. Hawn</u> Address <u>114</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatocarcinoma due to</u> <u>1-1-1</u> DUE TO (b) <u>Cirrhosis liver</u> if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>1-1-1</u> DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yrs.</u>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) county (State)
21 I certify that (I) (this hospital) attended the deceased from <u>6/1/1960</u> to <u>5/3/1967</u> , that (I) (we) last saw the deceased alive on <u>5/2/1967</u> , and that death occurred at <u>11:30 AM</u> from causes and on the date stated above.			
22a SIGNATURE <u>Stephen N. Jones</u>		22b DATE SIGNED <u>5/3/67</u>	
22c PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>		22d ADDRESS <u>809 Viers Mill Rd. Rockville, Maryland</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-6-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d LOCATION (City or town) (county) (State) <u>Silver Spring, Maryland</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REG-STRAR <u>MAY 8 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06887

06873

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c LENGTH OF STAY IN b <u>12 days</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>			d STREET ADDRESS <u>125 Monument Street</u>		
3 NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude W Hahn</u>			4 DATE OF DEATH Month Day Year <u>5 19 1967</u>		
5 SEX <u>F</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 2, 1907</u>	9 AGE (in years last birthday) <u>59</u> yrs	F UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS Mr
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Secretary</u>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>J. Clifford Wolf</u>			14 MOTHER'S MAIDEN NAME <u>Louise Stone Wolf</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>578-03-7658</u>	17 INFORMANT Address <u>Mr. Thomas Elwood 125 Monument Street Rockville, Maryland</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure - 3 days</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) <u>agitation</u> stating the underlying cause last <u>circulation of the heart</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>INTERVAL BETWEEN ONSET AND DEATH 24 hrs</u> <u>154</u>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item '8')		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/11/1967</u> to <u>3/19/1967</u> that (I) (we) last saw the deceased alive on <u>3/19/1967</u> and that death occurred at <u>2:30 PM</u> from causes and on the date stated above					
22a. SIGNATURE <u>Stephen N. Jones, M.D.</u>			22b. DATE SIGNED <u>5/22/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones, M.D.</u>			22d. ADDRESS <u>809 Veirs Mill Road, Rockville, Md.</u>		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
<u>Burial</u>	<u>5/22/67</u>	<u>Harmon Church Cemetery</u>		<u>Potomac Montgomery Maryland</u>	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE	
<u>Tyson Wheeler Funeral Home</u>		<u>1331 Rockville Pike</u>		<u>MAY 22 1967 Charles Judge</u>	
		<u>Rockville, Maryland</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

008883

CERTIFICATE OF DEATH

08376

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN <u>Rockville</u> (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN b <u>1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e STREET ADDRESS <u>1207 Vicks Mill Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Thomas H. Hawkes</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/5/13</u>
9 AGE (in years last birthday) <u>73</u> yrs		10 F UNDER 24 HRS Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>7</u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Contractor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>	
11 BIRTHPLACE (County & State or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Richard Hawkes</u>		14 MOTHER'S MAIDEN NAME <u>Marie Frank</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 1</u>		16 SOCIAL SECURITY NO. <u>425-24-3532-A</u>	
17 INFORMANT <u>Mary H. Hawkes-Item # 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) DUE TO (aa) DUE TO (ab) DUE TO (ac) DUE TO (ad) DUE TO (ae) DUE TO (af) DUE TO (ag) DUE TO (ah) DUE TO (ai) DUE TO (aj) DUE TO (ak) DUE TO (al) DUE TO (am) DUE TO (an) DUE TO (ao) DUE TO (ap) DUE TO (aq) DUE TO (ar) DUE TO (as) DUE TO (at) DUE TO (au) DUE TO (av) DUE TO (aw) DUE TO (ax) DUE TO (ay) DUE TO (az) DUE TO (ba) DUE TO (bb) DUE TO (bc) DUE TO (bd) DUE TO (be) DUE TO (bf) DUE TO (bg) DUE TO (bh) DUE TO (bi) DUE TO (bj) DUE TO (bk) DUE TO (bl) DUE TO (bm) DUE TO (bn) DUE TO (bo) DUE TO (bp) DUE TO (bq) DUE TO (br) DUE TO (bs) DUE TO (bt) DUE TO (bu) DUE TO (bv) DUE TO (bw) DUE TO (bx) DUE TO (by) DUE TO (bz) DUE TO (ca) DUE TO (cb) DUE TO (cc) DUE TO (cd) DUE TO (ce) DUE TO (cf) DUE TO (cg) DUE TO (ch) DUE TO (ci) DUE TO (cj) DUE TO (ck) DUE TO (cl) DUE TO (cm) DUE TO (cn) DUE TO (co) DUE TO (cp) DUE TO (cq) DUE TO (cr) DUE TO (cs) DUE TO (ct) DUE TO (cu) DUE TO (cv) DUE TO (cw) DUE TO (cx) DUE TO (cy) DUE TO (cz) DUE TO (da) DUE TO (db) DUE TO (dc) DUE TO (dd) DUE TO (de) DUE TO (df) DUE TO (dg) DUE TO (dh) DUE TO (di) DUE TO (dj) DUE TO (dk) DUE TO (dl) DUE TO (dm) DUE TO (dn) DUE TO (do) DUE TO (dp) DUE TO (dq) DUE TO (dr) DUE TO (ds) DUE TO (dt) DUE TO (du) DUE TO (dv) DUE TO (dw) DUE TO (dx) DUE TO (dy) DUE TO (dz) DUE TO (ea) DUE TO (eb) DUE TO (ec) DUE TO (ed) DUE TO (ee) DUE TO (ef) DUE TO (eg) DUE TO (eh) DUE TO (ei) DUE TO (ej) DUE TO (ek) DUE TO (el) DUE TO (em) DUE TO (en) DUE TO (eo) DUE TO (ep) DUE TO (eq) DUE TO (er) DUE TO (es) DUE TO (et) DUE TO (eu) DUE TO (ev) DUE TO (ew) DUE TO (ex) DUE TO (ey) DUE TO (ez) DUE TO (fa) DUE TO (fb) DUE TO (fc) DUE TO (fd) DUE TO (fe) DUE TO (ff) DUE TO (fg) DUE TO (fh) DUE TO (fi) DUE TO (fj) DUE TO (fk) DUE TO (fl) DUE TO (fm) DUE TO (fn) DUE TO (fo) DUE TO (fp) DUE TO (fq) DUE TO (fr) DUE TO (fs) DUE TO (ft) DUE TO (fu) DUE TO (fv) DUE TO (fw) DUE TO (fx) DUE TO (fy) DUE TO (fz) DUE TO (ga) DUE TO (gb) DUE TO (gc) DUE TO (gd) DUE TO (ge) DUE TO (gf) DUE TO (gg) DUE TO (gh) DUE TO (gi) DUE TO (gj) DUE TO (gk) DUE TO (gl) DUE TO (gm) DUE TO (gn) DUE TO (go) DUE TO (gp) DUE TO (gq) DUE TO (gr) DUE TO (gs) DUE TO (gt) DUE TO (gu) DUE TO (gv) DUE TO (gw) DUE TO (gx) DUE TO (gy) DUE TO (gz) DUE TO (ha) DUE TO (hb) DUE TO (hc) DUE TO (hd) DUE TO (he) DUE TO (hf) DUE TO (hg) DUE TO (hh) DUE TO (hi) DUE TO (hj) DUE TO (hk) DUE TO (hl) DUE TO (hm) DUE TO (hn) DUE TO (ho) DUE TO (hp) DUE TO (hq) DUE TO (hr) DUE TO (hs) DUE TO (ht) DUE TO (hu) DUE TO (hv) DUE TO (hw) DUE TO (hx) DUE TO (hy) DUE TO (hz) DUE TO (ia) DUE TO (ib) DUE TO (ic) DUE TO (id) DUE TO (ie) DUE TO (if) DUE TO (ig) DUE TO (ih) DUE TO (ii) DUE TO (ij) DUE TO (ik) DUE TO (il) DUE TO (im) DUE TO (in) DUE TO (io) DUE TO (ip) DUE TO (iq) DUE TO (ir) DUE TO (is) DUE TO (it) DUE TO (iu) DUE TO (iv) DUE TO (iw) DUE TO (ix) DUE TO (iy) DUE TO (iz) DUE TO (ja) DUE TO (jb) DUE TO (jc) DUE TO (jd) DUE TO (je) DUE TO (jf) DUE TO (jg) DUE TO (jh) DUE TO (ji) DUE TO (jj) DUE TO (jk) DUE TO (jl) DUE TO (jm) DUE TO (jn) DUE TO (jo) DUE TO (jp) DUE TO (jq) DUE TO (jr) DUE TO (js) DUE TO (jt) DUE TO (ju) DUE TO (jv) DUE TO (jw) DUE TO (jx) DUE TO (jy) DUE TO (jz) DUE TO (ka) DUE TO (kb) DUE TO (kc) DUE TO (kd) DUE TO (ke) DUE TO (kf) DUE TO (kg) DUE TO (kh) DUE TO (ki) DUE TO (kj) DUE TO (kl) DUE TO (km) DUE TO (kn) DUE TO (ko) DUE TO (kp) DUE TO (kq) DUE TO (kr) DUE TO (ks) DUE TO (kt) DUE TO (ku) DUE TO (kv) DUE TO (kw) DUE TO (kx) DUE TO (ky) DUE TO (kz) DUE TO (la) DUE TO (lb) DUE TO (lc) DUE TO (ld) DUE TO (le) DUE TO (lf) DUE TO (lg) DUE TO (lh) DUE TO (li) DUE TO (lj) DUE TO (lk) DUE TO (ll) DUE TO (lm) DUE TO (ln) DUE TO (lo) DUE TO (lp) DUE TO (lq) DUE TO (lr) DUE TO (ls) DUE TO (lt) DUE TO (lu) DUE TO (lv) DUE TO (lw) DUE TO (lx) DUE TO (ly) DUE TO (lz) DUE TO (ma) DUE TO (mb) DUE TO (mc) DUE TO (md) DUE TO (me) DUE TO (mf) DUE TO (mg) DUE TO (mh) DUE TO (mi) DUE TO (mj) DUE TO (mk) DUE TO (ml) DUE TO (mm) DUE TO (mn) DUE TO (mo) DUE TO (mp) DUE TO (mq) DUE TO (mr) DUE TO (ms) DUE TO (mt) DUE TO (mu) DUE TO (mv) DUE TO (mw) DUE TO (mx) DUE TO (my) DUE TO (mz) DUE TO (na) DUE TO (nb) DUE TO (nc) DUE TO (nd) DUE TO (ne) DUE TO (nf) DUE TO (ng) DUE TO (nh) DUE TO (ni) DUE TO (nj) DUE TO (nk) DUE TO (nl) DUE TO (nm) DUE TO (nn) DUE TO (no) DUE TO (np) DUE TO (nq) DUE TO (nr) DUE TO (ns) DUE TO (nt) DUE TO (nu) DUE TO (nv) DUE TO (nw) DUE TO (nx) DUE TO (ny) DUE TO (nz) DUE TO (oa) DUE TO (ob) DUE TO (oc) DUE TO (od) DUE TO (oe) DUE TO (of) DUE TO (og) DUE TO (oh) DUE TO (oi) DUE TO (oj) DUE TO (ok) DUE TO (ol) DUE TO (om) DUE TO (on) DUE TO (oo) DUE TO (op) DUE TO (oq) DUE TO (or) DUE TO (os) DUE TO (ot) DUE TO (ou) DUE TO (ov) DUE TO (ow) DUE TO (ox) DUE TO (oy) DUE TO (oz) DUE TO (pa) DUE TO (pb) DUE TO (pc) DUE TO (pd) DUE TO (pe) DUE TO (pf) DUE TO (pg) DUE TO (ph) DUE TO (pi) DUE TO (pj) DUE TO (pk) DUE TO (pl) DUE TO (pm) DUE TO (pn) DUE TO (po) DUE TO (pp) DUE TO (pq) DUE TO (pr) DUE TO (ps) DUE TO (pt) DUE TO (pu) DUE TO (pv) DUE TO (pw) DUE TO (px) DUE TO (py) DUE TO (pz) DUE TO (qa) DUE TO (qb) DUE TO (qc) DUE TO (qd) DUE TO (qe) DUE TO (qf) DUE TO (qg) DUE TO (qh) DUE TO (qi) DUE TO (qj) DUE TO (qk) DUE TO (ql) DUE TO (qm) DUE TO (qn) DUE TO (qo) DUE TO (qp) DUE TO (qq) DUE TO (qr) DUE TO (qs) DUE TO (qt) DUE TO (qu) DUE TO (qv) DUE TO (qw) DUE TO (qx) DUE TO (qy) DUE TO (qz) DUE TO (ra) DUE TO (rb) DUE TO (rc) DUE TO (rd) DUE TO (re) DUE TO (rf) DUE TO (rg) DUE TO (rh) DUE TO (ri) DUE TO (rj) DUE TO (rk) DUE TO (rl) DUE TO (rm) DUE TO (rn) DUE TO (ro) DUE TO (rp) DUE TO (rq) DUE TO (rr) DUE TO (rs) DUE TO (rt) DUE TO (ru) DUE TO (rv) DUE TO (rw) DUE TO (rx) DUE TO (ry) DUE TO (rz) DUE TO (sa) DUE TO (sb) DUE TO (sc) DUE TO (sd) DUE TO (se) DUE TO (sf) DUE TO (sg) DUE TO (sh) DUE TO (si) DUE TO (sj) DUE TO (sk) DUE TO (sl) DUE TO (sm) DUE TO (sn) DUE TO (so) DUE TO (sp) DUE TO (sq) DUE TO (sr) DUE TO (ss) DUE TO (st) DUE TO (su) DUE TO (sv) DUE TO (sw) DUE TO (sx) DUE TO (sy) DUE TO (sz) DUE TO (ta) DUE TO (tb) DUE TO (tc) DUE TO (td) DUE TO (te) DUE TO (tf) DUE TO (tg) DUE TO (th) DUE TO (ti) DUE TO (tj) DUE TO (tk) DUE TO (tl) DUE TO (tm) DUE TO (tn) DUE TO (to) DUE TO (tp) DUE TO (tq) DUE TO (tr) DUE TO (ts) DUE TO (tt) DUE TO (tu) DUE TO (tv) DUE TO (tw) DUE TO (tx) DUE TO (ty) DUE TO (tz) DUE TO (ua) DUE TO (ub) DUE TO (uc) DUE TO (ud) DUE TO (ue) DUE TO (uf) DUE TO (ug) DUE TO (uh) DUE TO (ui) DUE TO (uj) DUE TO (uk) DUE TO (ul) DUE TO (um) DUE TO (un) DUE TO (uo) DUE TO (up) DUE TO (uq) DUE TO (ur) DUE TO (us) DUE TO (ut) DUE TO (uu) DUE TO (uv) DUE TO (uw) DUE TO (ux) DUE TO (uy) DUE TO (uz) DUE TO (va) DUE TO (vb) DUE TO (vc) DUE TO (vd) DUE TO (ve) DUE TO (vf) DUE TO (vg) DUE TO (vh) DUE TO (vi) DUE TO (vj) DUE TO (vk) DUE TO (vl) DUE TO (vm) DUE TO (vn) DUE TO (vo) DUE TO (vp) DUE TO (vq) DUE TO (vr) DUE TO (vs) DUE TO (vt) DUE TO (vu) DUE TO (vv) DUE TO (vw) DUE TO (vx) DUE TO (vy) DUE TO (vz) DUE TO (wa) DUE TO (wb) DUE TO (wc) DUE TO (wd) DUE TO (we) DUE TO (wf) DUE TO (wg) DUE TO (wh) DUE TO (wi) DUE TO (wj) DUE TO (wk) DUE TO (wl) DUE TO (wm) DUE TO (wn) DUE TO (wo) DUE TO (wp) DUE TO (wq) DUE TO (wr) DUE TO (ws) DUE TO (wt) DUE TO (wu) DUE TO (wv) DUE TO (ww) DUE TO (wx) DUE TO (wy) DUE TO (wz) DUE TO (xa) DUE TO (xb) DUE TO (xc) DUE TO (xd) DUE TO (xe) DUE TO (xf) DUE TO (xg) DUE TO (xh) DUE TO (xi) DUE TO (xj) DUE TO (xk) DUE TO (xl) DUE TO (xm) DUE TO (xn) DUE TO (xo) DUE TO (xp) DUE TO (xq) DUE TO (xr) DUE TO (xs) DUE TO (xt) DUE TO (xu) DUE TO (xv) DUE TO (xw) DUE TO (xx) DUE TO (xy) DUE TO (xz) DUE TO (ya) DUE TO (yb) DUE TO (yc) DUE TO (yd) DUE TO (ye) DUE TO (yf) DUE TO (yg) DUE TO (yh) DUE TO (yi) DUE TO (yj) DUE TO (yk) DUE TO (yl) DUE TO (ym) DUE TO (yn) DUE TO (yo) DUE TO (yp) DUE TO (yq) DUE TO (yr) DUE TO (ys) DUE TO (yt) DUE TO (yu) DUE TO (yv) DUE TO (yw) DUE TO (yx) DUE TO (yy) DUE TO (yz) DUE TO (za) DUE TO (zb) DUE TO (zc) DUE TO (zd) DUE TO (ze) DUE TO (zf) DUE TO (zg) DUE TO (zh) DUE TO (zi) DUE TO (zj) DUE TO (zk) DUE TO (zl) DUE TO (zm) DUE TO (zn) DUE TO (zo) DUE TO (zp) DUE TO (zq) DUE TO (zr) DUE TO (zs) DUE TO (zt) DUE TO (zu) DUE TO (zv) DUE TO (zw) DUE TO (zx) DUE TO (zy) DUE TO (zz)			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A12 (4)
20 M 1/66

CERTIFICATE OF DEATH

06890

06375

1 PLACE OF BIRTH a COUNTY Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Elizabeth's Hospital		d. STREET ADDRESS 500 North Street		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Robert Lee		First Middle Last Robert Lee		4 DATE OF DEATH Month Day Year May 15 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 5, 1883	9 AGE (In years last birthday) 83 yrs	10 UNDER 1 YEAR Months Days Hours Min
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. U.S. Army		11b. KIND OF BUSINESS OR INDUSTRY Capt. Construction		12 CITIZEN OF WHAT COUNTRY? United States	
13 FATHER'S NAME Robert Lee		14 MOTHER'S MAIDEN NAME Mary Lee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO 5-11-67		17 INFORMANT Address 500 North Street	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2-3 years					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 13 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 13, 1967, to May 15, 1967, that (I) (we) last saw the deceased alive on May 15, 1967, and that death occurred at 4:45 AM, from causes and on the date stated above.					
22a SIGNATURE Thomas Perry		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 5-15-67	
22c. PHYSICIAN'S NAME (Type) Thomas Perry		22d. ADDRESS 11,002 Georgia Avenue			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Prince George's County, Maryland	
24 FUNERAL DIRECTOR Address		25a. RECEIVED BY REGISTRAR DATE MAY 15 1967		25b REGISTRAR'S SIGNATURE James J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06891

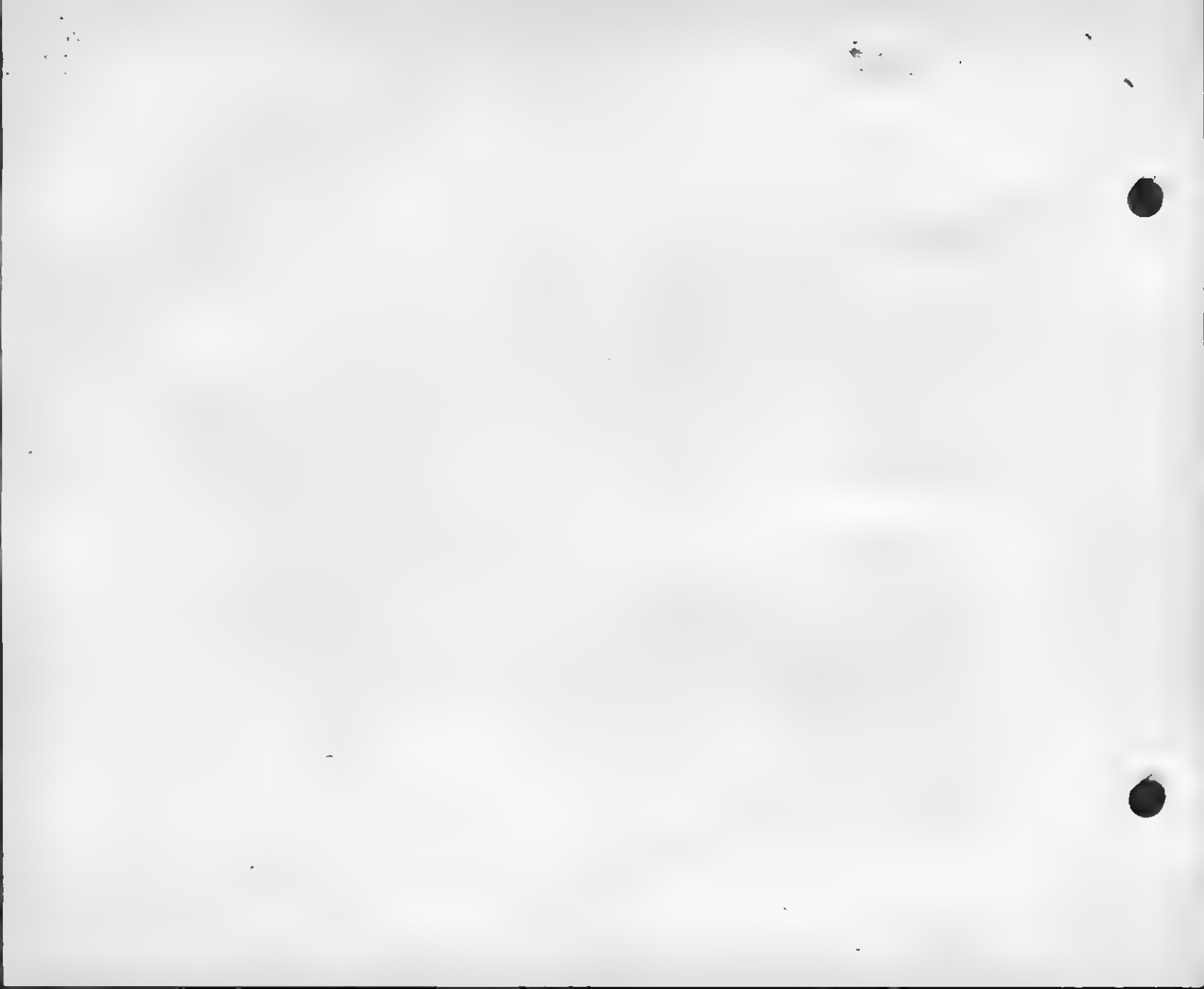
CERTIFICATE OF DEATH

06876

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if not institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN b <u>1 Day</u>			
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d STREET ADDRESS <u>9407 Singleton Drive</u>			
3 NAME OF DECEASED (Type or print) <u>Jesse E. Heitmuller</u>				4 DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1967</u>			
5 SEX <u>male</u>	6 CO. OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/13/94</u>		9 AGE (In years) <u>73</u> yrs	10 F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13 FATHER'S NAME <u>Otto Heitmuller</u>				14 MOTHER'S MAIDEN NAME <u>Augusta Dietz</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOC. A. SECURITY NO. <u>578-05-4761</u>		17 INFORMANT <u>9205 Quintana Dr, Bethesda Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET, AND DEATH <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>42</u> to <u>5/19</u> - 19 <u>67</u> , that () (we) last saw the deceased alive on <u>5/19</u> 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above							
22a SIGNATURE <u>Paul D. Cantor</u>			M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b DATE SIGNED <u>5/21/67</u>		
22c PHYSICIAN'S NAME (Type) <u>PAUL D. CANTOR</u>			22d ADDRESS <u>4709 Montgomery Lane Bethesda, Maryland</u>				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
<u>Burial</u>		<u>5-23-67</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a REC'D BY REGISTRAR <u>MAY 24 1967</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06892

CERTIFICATE OF DEATH

06877

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>14 10mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Marquerite</u> Middle <u>A</u> Last <u>Henry</u>		4 DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 21 1892</u>
9 AGE (in years, last birthday) <u>75</u> yrs		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>James J. Connor</u>	
14 MOTHER'S MAIDEN NAME <u>Nellie Jordan</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO.		17 INFORMANT <u>Mr Francis J. Henry</u> Address <u>Arlington, Va.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>May 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-8</u> 1967, and that death occurred at <u>7:20</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>S. J. Randall</u>		22b DATE SIGNED <u>5-8-67</u>	
22c PHYSICIAN'S NAME (Type) <u>S. J. RANDALL, MD</u>		22d ADDRESS <u>3001 Veazey Terr. NW DC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>May 11 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEM.</u>		23d LOCATION (City or town) (County) (State) <u>ARLINGTON VA.</u>	
24 FUNERAL DIRECTOR <u>ARLINGTON FUNERAL HOME</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 12 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26893

06878

1 PLACE OF DEATH a COUNTY <u>Howard</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst llt or Residence before admision) a STATE <u>Dist. of Columbia</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN TB <u>8 days</u>	
d NAME OF HOSPITAL OR INST TUTION (If not in hospital give street address) <u>Holy Cross of Silver Spring</u>		d STREET ADDRESS <u>1308 RANOLPH ST NW</u>	
3 NAME OF DECEASED (Type or print) <u>WILTON F HENSON</u>		4 DATE OF DEATH <u>14 May 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Black</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/8/05</u>
9 AGE (in years last birthday) <u>61 yrs</u>		10 IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>61</u> Min <u>1</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>UNKNOWN</u>		14 MOTHER'S MAIDEN NAME <u>SALLIE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>SARAH H. HENSON -WIFE</u>		Address <u>1308 RANOLPH ST. NW</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Branchogenic Carcinoma</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Relatoricobacter pneumonia</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> pm	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>September 1966</u> to <u>May 1967</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>67</u> , and that death occurred at <u>11:45</u> A.M. from causes and on the date stated above			
22a SIGNATURE <u>Blaine H. ETC</u>		22b DATE SIGNED <u>May 14</u>	
22c PHYSICIAN'S NAME (Type) <u>BLAINE H. ETC</u>		22d ADDRESS <u>Blaine H. ETC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>4-11-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Wt Olmsted Cem</u>	23d LOCATION (City or Town) (County) (State) <u>DC</u>
24 FUNERAL DIRECTOR <u>John T. Rhoads</u>		25 REGISTERED REGISTRAR <u>3015 12th St NE</u>	
25a REGISTERED REGISTRAR <u>3015 12th St NE</u>		25b REGISTRAR'S SIGNATURE <u>John T. Rhoads</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, if necessary, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06894

CERTIFICATE OF DEATH

06879

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Res. before adm.) a. STATE <u>Poolesville, Md.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Clney,</u>				c. LENGTH OF STAY In <u>14 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Beulah Kazier Hickman</u>				4. DATE OF DEATH Month Day Year <u>May 3 19 67</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/87</u>		9 AGE (in years last birthday) yrs <u>80</u>		10 UNDER 24 HRS Months Days Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>Daniel Morningstar</u>				14 MOTHER'S MAIDEN NAME <u>Susan Stitley</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>218-30-2609</u>		17 INFORMANT <u>Medical Records, Montg. General Hospital</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intra-uterine carcinoma -</u> DUE TO (b) <u>Primary site unknown</u> DUE TO (c) <u>Primary site unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal bronchopneumonia</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Apr 19, 1967</u> to <u>May 3, 1967</u> that (I) (we) last saw the deceased alive on <u>May 3, 1967</u> , and that death occurred at <u>7 P.M.</u> from cause and on the date stated above.							
22a. SIGNATURE <u>Constance C. Helton</u>				22b. DATES GIVEN <u>May 3-1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Constance C. Helton</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	
24. FUNERAL DIRECTOR <u>Constance C. Helton</u>				25a. REC'D BY REGISTRAR <u>Barnesville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Wes Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00895

CERTIFICATE OF DEATH

00880

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7101 W. Greenvale Parkway		d. STREET ADDRESS 7101 Greenvale Parkway	
3. NAME OF DECEASED (Type or print) SUSIE First B Middle HORTON Last		4 DATE OF DEATH MAY 23 19 67 Month Day Year	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 4, 1876
9 AGE (In years last birthday) 91 yrs		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME David Franklin Baird		14 MOTHER'S MAIDEN NAME Elizabeth Wagner	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Daughter Address Same as Item 2. Mary H. Duncan			
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) GEN. ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 10 days 3 yrs 10 yrs	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 pm	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (has hospital) attended the deceased from May 11 , 19 67 , to MAY 23 , 19 67 that (I) (was) last saw the deceased alive on MAY 23 , 19 67 , and that death occurred at 6:30 AM , from causes and on the date stated above.			
22a SIGNATURE B.R. Cooperman, M.D.		22b DATE SIGNED May 23, 1967	
22c PHYSICIAN'S NAME (Type) B.R. COOPERMAN, M.D.		22d ADDRESS 1302-18 St. N.W. WASH. DC.	
23a BURIAL, CREMATION, REMOVA (Specify) Burial	23b DATE THEREOF May 24 1967	23c NAME OF CEMETERY OR CREMATORY Davidsonville Cemetery	23d LOCATION (City or Town) (County) (State) Davidsonville, Md.
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR MAY 24 1967	25b REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06896

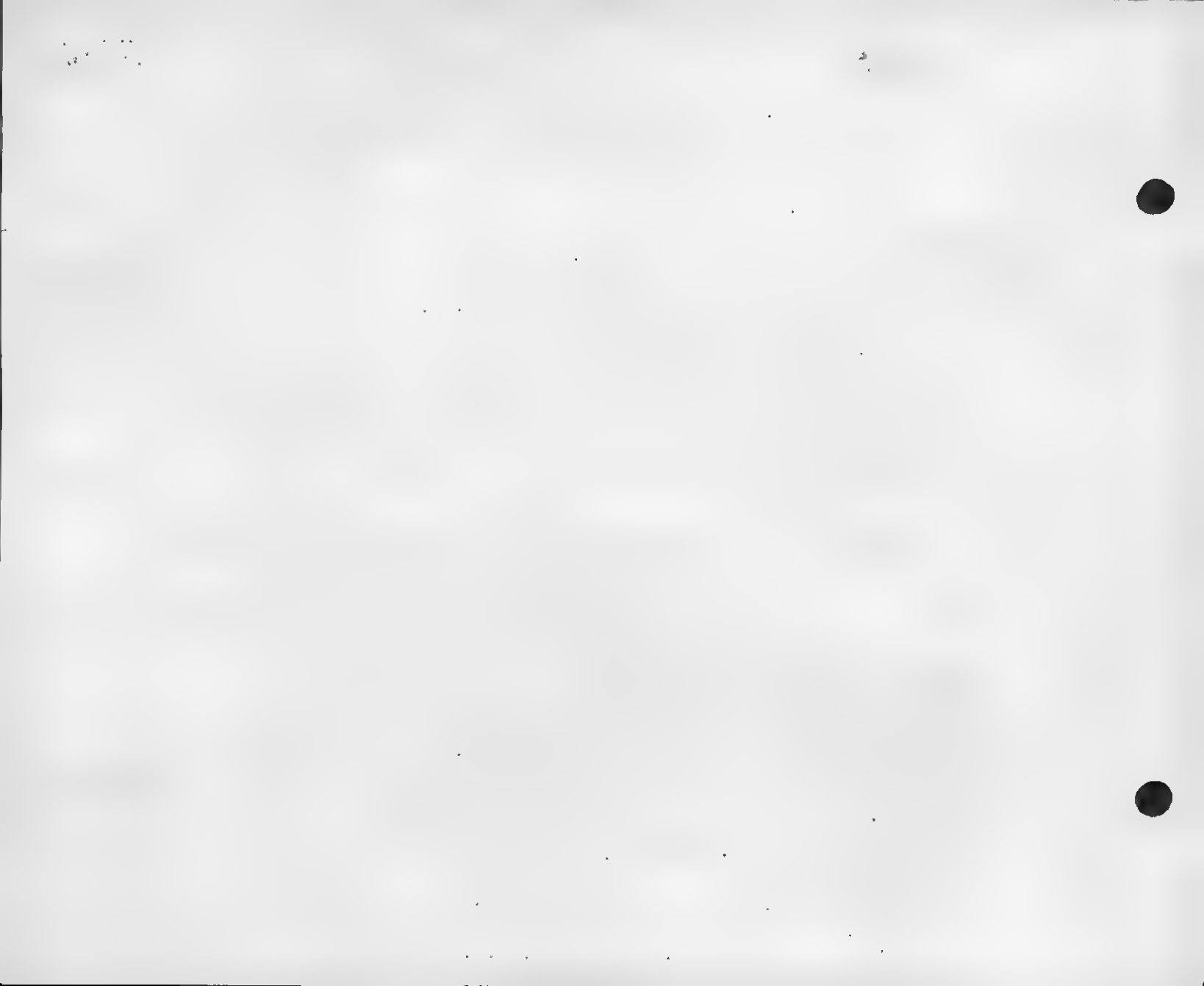
CERTIFICATE OF DEATH

06881

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 83 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS RFD #1, Glamorgan	
3. NAME OF DECEASED (Type or print) Lunsford Lomas HUNTER		4. DATE OF DEATH Month May Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1888
9. AGE (In years last birthday) yrs 78		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Navy--Racing Farm		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Doswell, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles M. Hunter		14. MOTHER'S MAIDEN NAME Lucy Pearce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI and II		16. SOCIAL SECURITY NO 228 42 9453	
17. INFORMANT Doswell Address Virginia Mrs. Marian Hunter, RFD #1, Glamorgan			
18. CAUSE OF DEATH (Enter on y one cause per one for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO (b) Recurrent adenocarcinoma of colon with metastases DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from Feb. 22, 1967 , to May 16, 1967 , that (a) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 750 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Halbert E. Ashworth</i>		22b. DATE SIGNED 17 May 1967	
22c. PHYSICIAN'S NAME (Type) Halbert E. ASHWORTH, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF 5-18-1967	23c. NAME OF CEMETERY OR CREMATORY Old Fork Episcopal Church Cemetery	23d. LOCATION (City or Town) (County) (State) Doswell Virginia
24. FUNERAL DIRECTOR Jos. H. Gawler & Sons		25a. REC'D BY REG. STRAR DATE MAY 22 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36897

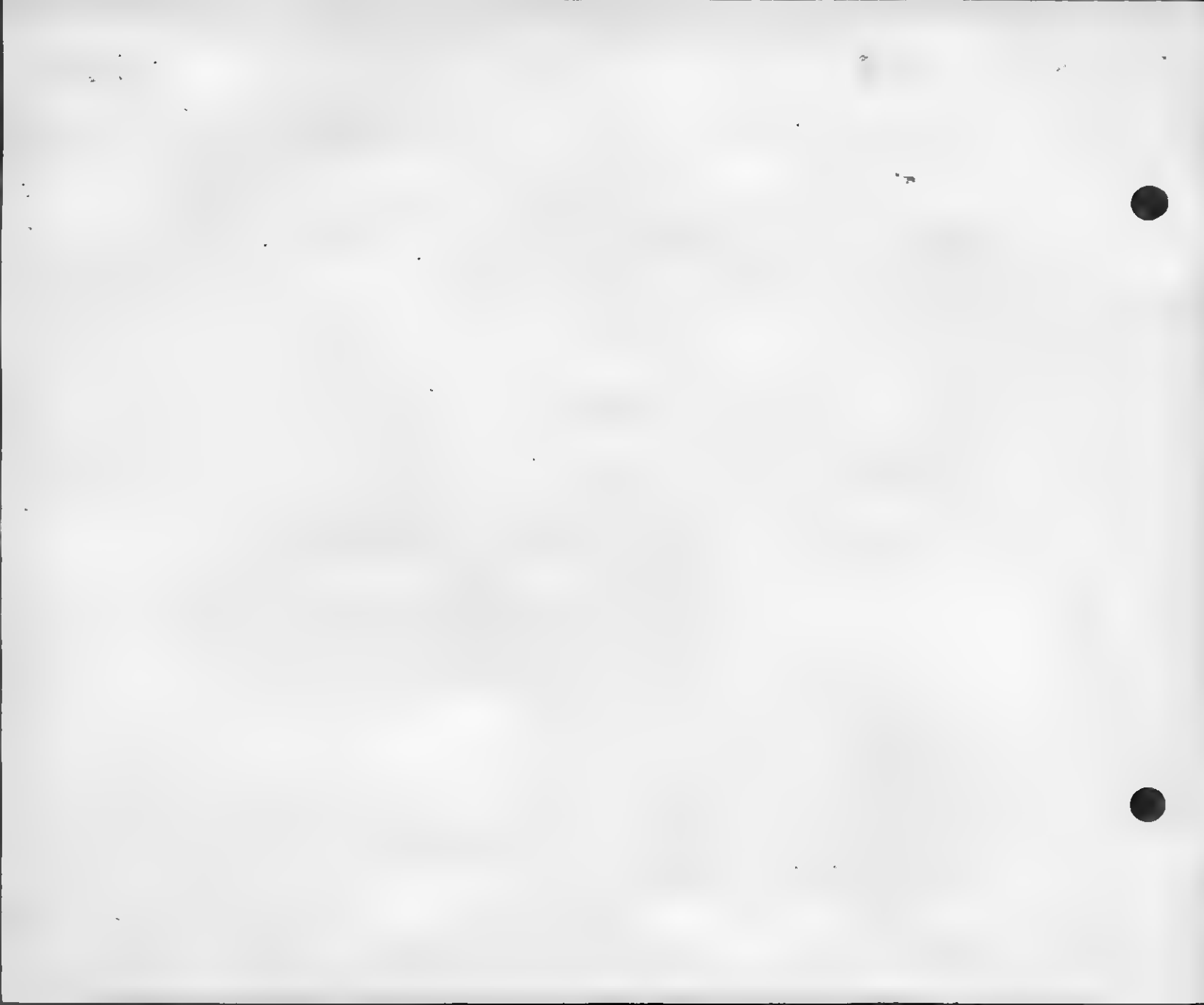
CERTIFICATE OF DEATH

06882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>KENSINGTON</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>		e STREET ADDRESS <u>106 Charles Street</u>	
3 NAME OF DECEASED (Type or print) First <u>DICK</u> Middle <u>LEE</u> Last <u>HURST</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 22 1897</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9 AGE (in years last birthday) <u>69</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>HENRY HURST</u>		14 MOTHER'S MAIDEN NAME <u>ADELAIDE HINSON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>Howard Hurst-Son</u>	
17 INFORMANT <u>Howard Hurst-Son</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Urinary Tract Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 wks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized A.S., ASHD, ASCVD</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-7-64</u> to <u>5-15-67</u> , that (I) (we) last saw the deceased alive on <u>5-14-67</u> , and that death occurred at <u>6:30</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>G. F. Sengstack M.D.</u>		22b DATE SIGNED <u>5-15-67</u>	
22c PHYSICIAN'S NAME (Type) <u>G. F. Sengstack</u>		22d ADDRESS <u>9241 Columbia Boulevard</u> <u>Silver Spring, Maryland</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/17/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Rockville, Montg. Maryland</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a REC'D BY REGISTRAR <u>1331 Rockville Pk</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c DATE <u>MAY 18 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

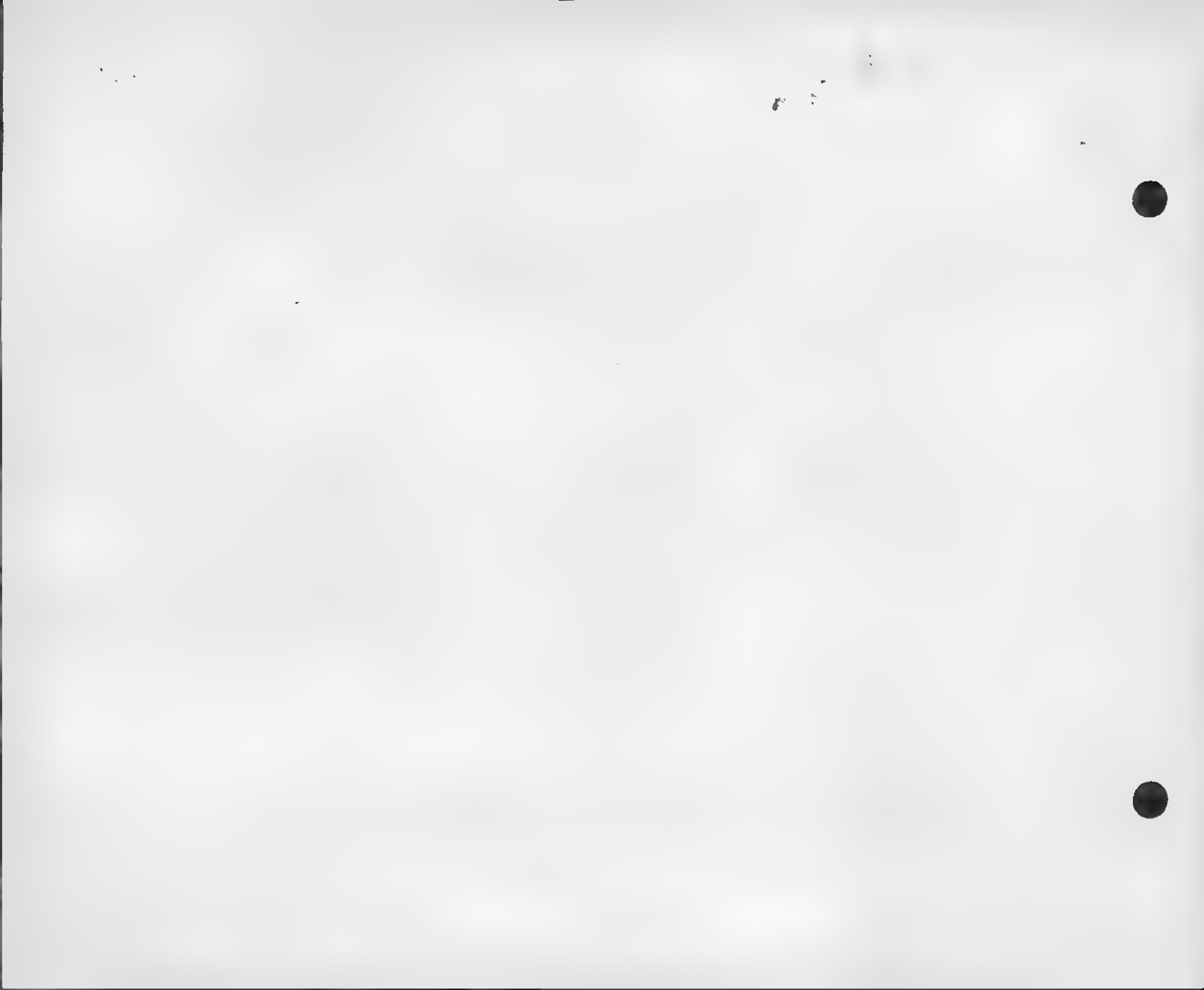
CERTIFICATE OF DEATH

26893

06883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB NEW HAVEN		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE CONNECTICUT b. COUNTY NEW HAVEN	
d. NAME OF HOSPITAL, DR INSTITUTE (if not in hospital, give street address) CHEVY CHASE NURSING AND CONVALESCENT Center		d. STREET ADDRESS 44 HIGHLAND ST. 2015 EAST WEST HIGHWAY	
3 NAME OF DECEASED (Type or print) First Middle Last KATE (N/A) ILLICH		4 DATE OF DEATH Month Day Year MAY 6 1967	
5 SEX FEMALE	6 COLOR OR RACE CAUC	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH NOV 24 1885
9 AGE (in years last birthday) 81		10 UNDER 1 YEAR Months Days Hours Min 6 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY AT HOME	
11 BIRTHPLACE (County & State, or foreign country) POKAND GERMANY		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME (UNKNOWN) ULLMANN		14 MOTHER'S MAIDEN NAME UNKNOWN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NONE		16 SOCIAL SECURITY NO UNKNOWN	
17 INFORMANT ANDREW G. KUTNER		Address BELTSVILLE, MD 13108 GREENMOUNT AVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Coronary artery disease DUE TO (c) Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 12 hr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 4-5-1967 to 5-6-1967 that (I) (we) last saw the deceased alive on 5-4-1967 , and that death occurred at 10 PM , from causes and on the date stated above			
22a SIGNATURE Herbert L. Tanenbaum MD		22b DATE SIGNED 5/6/1967	
22c PHYSICIAN'S NAME (Type) Herbert L. Tanenbaum		22d ADDRESS 44 Highland St. New Haven Conn	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5/9/1967	PARKLAND CEM	ROCKVILLE, MONTGOMERY MD
24. FUNERAL DIRECTOR W.W. CHAMBERS INC. SILVER SPRING, MD		25a REC'D BY REGISTRAR DATE MAY 11 1967	
		25b REGISTRAR'S SIGNATURE Johnes Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

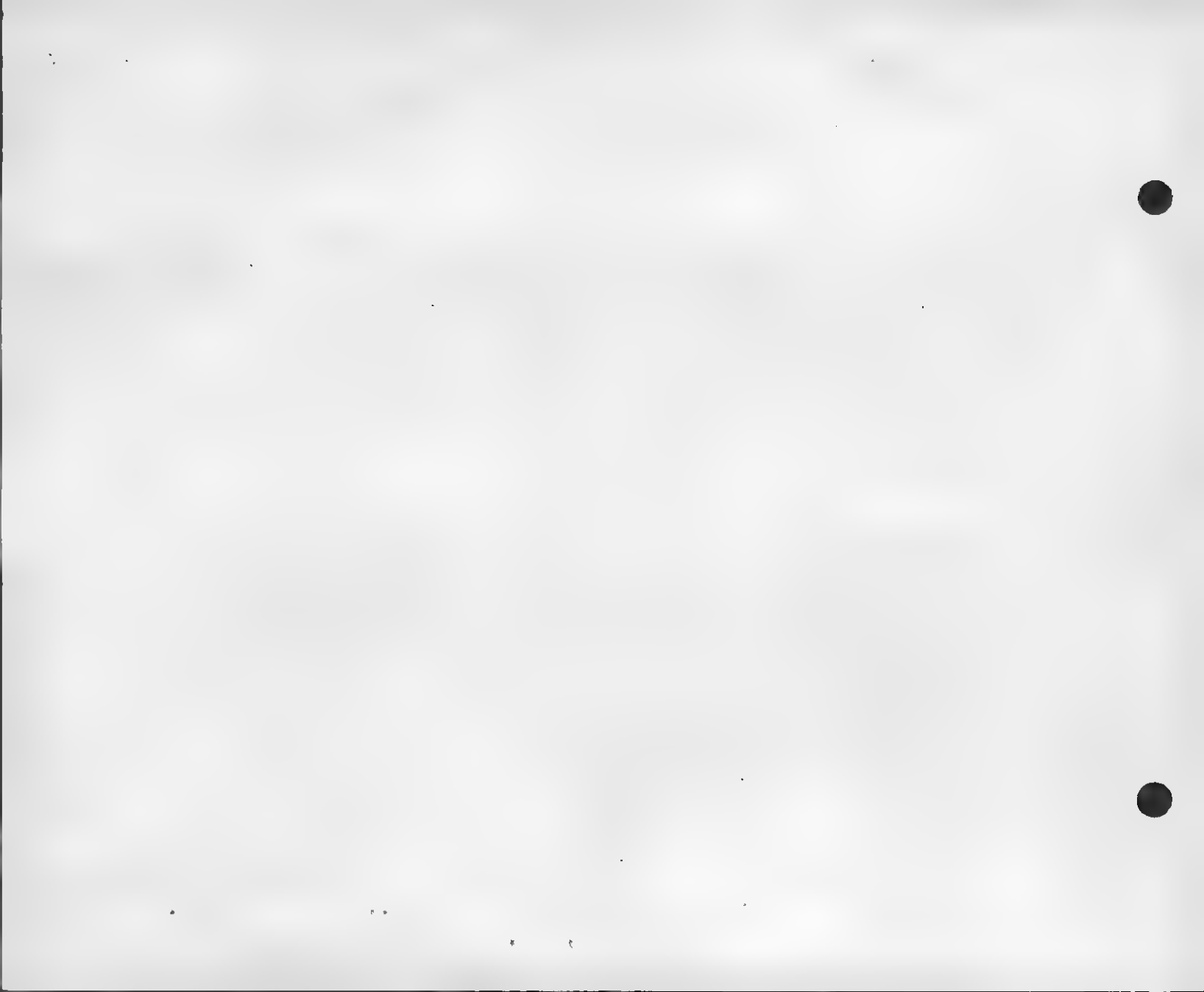
06893

CERTIFICATE OF DEATH

06884

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u> c LENGTH OF STAY IN 1b <u>10</u>		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> d STREET ADDRESS <u>Route 2</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Henry Robert Jackson</u> First Middle Last		4 DATE OF DEATH <u>May 4</u> 19 <u>67</u> Month Day Year	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <u>May 22 - 1899</u>
9 AGE (In years last birthday) <u>75</u> yrs IF UNDER 1 YEAR: Months <u>5</u> Days <u>18</u> IF UNDER 24 HRS: Hours <u>18</u> Min <u>00</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> 10b KIND OF BUSINESS OR INDUSTRY <u>Farm</u> 11 BIRTHPLACE (County & State or foreign country) <u>Seneca, Montg. Co., Md</u> 12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Henry Hall Jackson</u>		14 MOTHER'S MAIDEN NAME <u>Barbara Chipper</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>217-36-0368</u>	
17 INFORMANT <u>Virginia F Jackson, R2-Germantown, Md</u> Address		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right hemiparesis, following cerebrovascular accident</u> (b) <u>490</u> (c) <u>5 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Repeated hemiplegia since Jan - 25, 1961</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> pm <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan - 1 - 1961</u> , to <u>May - 4 - 1967</u> , that (I) (we) last saw the deceased alive on <u>May - 4 - 1967</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>William C. Miller, M.D.</u> 22c PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER M.D.</u>		22d ADDRESS <u>7-Brooks Ave., Gaithersburg, Md.</u>	
23a BURIAL, CREMATION, REINTERMENT <u>Reinterred</u>	23b DATE THEREOF <u>5-7-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Seneca Community.,</u>	23d LOCATION (City or town) (County) (State) <u>Seneca, Md.</u>
24 FUNERAL DIRECTOR <u>Rockville, Md.</u>		25a REC'D BY REGISTRAR DATE <u>Y 11 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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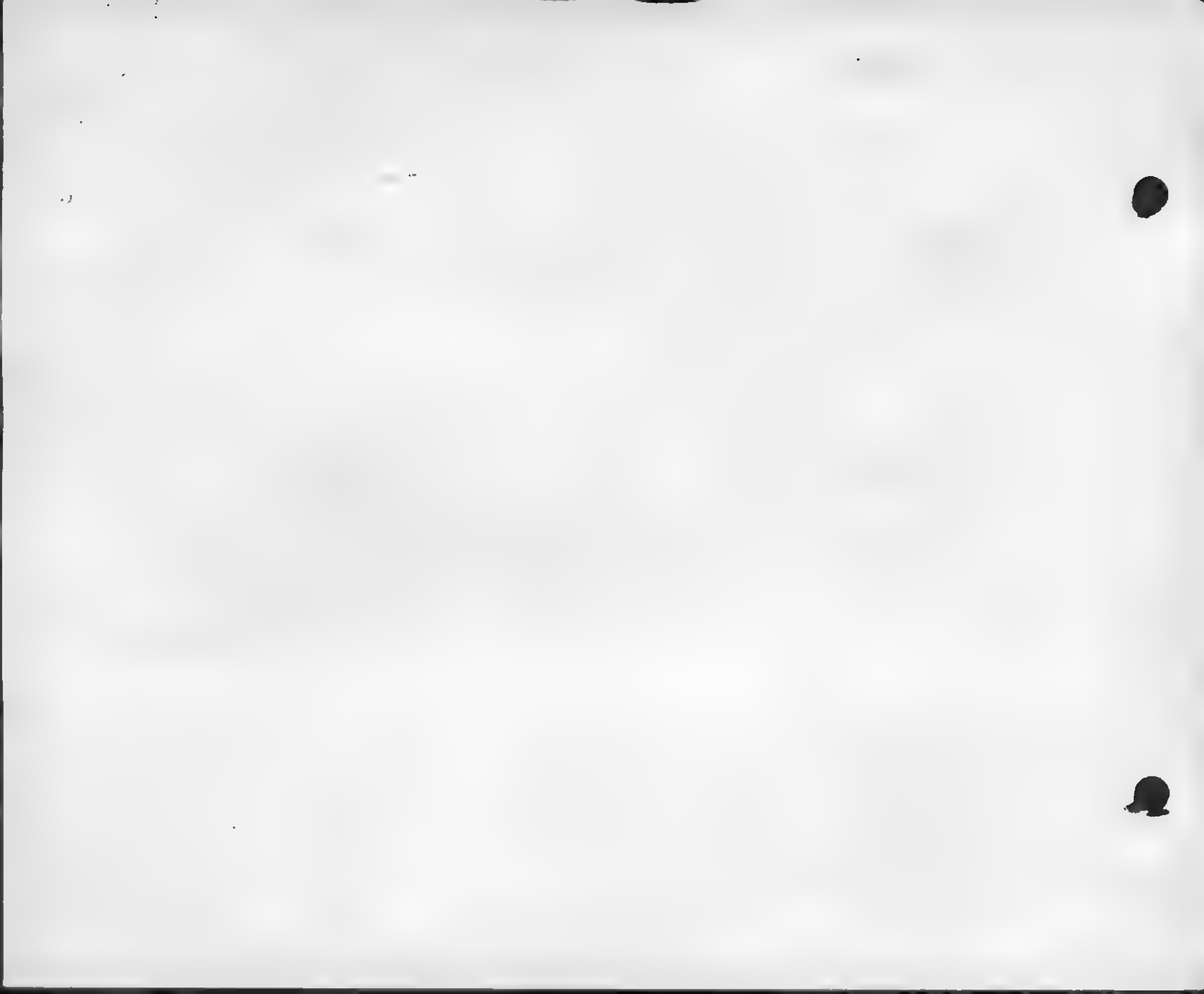
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Cleared by Dr. Reap, Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06300					CERTIFICATE OF DEATH			06885		
1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c LENGTH OF STAY N 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POLY CROSS HOSPITAL OF SILVER SPRING</u>					d STREET ADDRESS <u>12607 LITTLETON STREET</u>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last <u>MAX</u> <u>JAFFE</u>					4 DATE OF DEATH Month Day Year <u>MAY</u> <u>11</u> <u>19 67</u>					
5 SEX <u>MALE</u>		6 COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12-23-1893</u>		9 AGE (In years lost birthday) yrs <u>73</u>		
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>TAILOR</u>				10b KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11 BIRTHPLACE (County & State or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13 FATHER'S NAME <u>Unknown</u>					14 MOTHER'S MAIDEN NAME <u>Unknown</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			6 SOCIAL SECURITY NO <u>473-01-0824</u>		17 INFORMANT Address <u>Jeanne Gevinson, Same as 2</u>					
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Severe Coronary artery disease</u> DUE TO (c) <u>and severe myocardial disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>12 years</u> <u>12 years</u>		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus, Pernicious Anemia</u>								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 1B) <u>None</u>							
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> p.m.			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10-1-</u> , 19 <u>56</u> , to <u>May 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> , 19 <u>67</u> , and that death occurred at <u>2:27 A</u> M, from causes and on the date stated above										
22a SIGNATURE <u>Leo J. Schildhaus</u>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>5-11-67</u>			
22c PHYSICIAN'S NAME (Type) <u>LEO J. SCHILDHAUS, M.D.</u>					22d ADDRESS <u>5750 WISCONSIN AVE, CHEVY CHASE, MD.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>5-12-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>NAT'L MEMORIAL PARK</u>		23d LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>				
24 FUNERAL DIRECTOR <u>GOLDENBERG FUNERAL HOME</u>					ADDRESS <u>4217 9th Street N.W.</u>		25a REGD. BY REGISTRAR <u>MAY 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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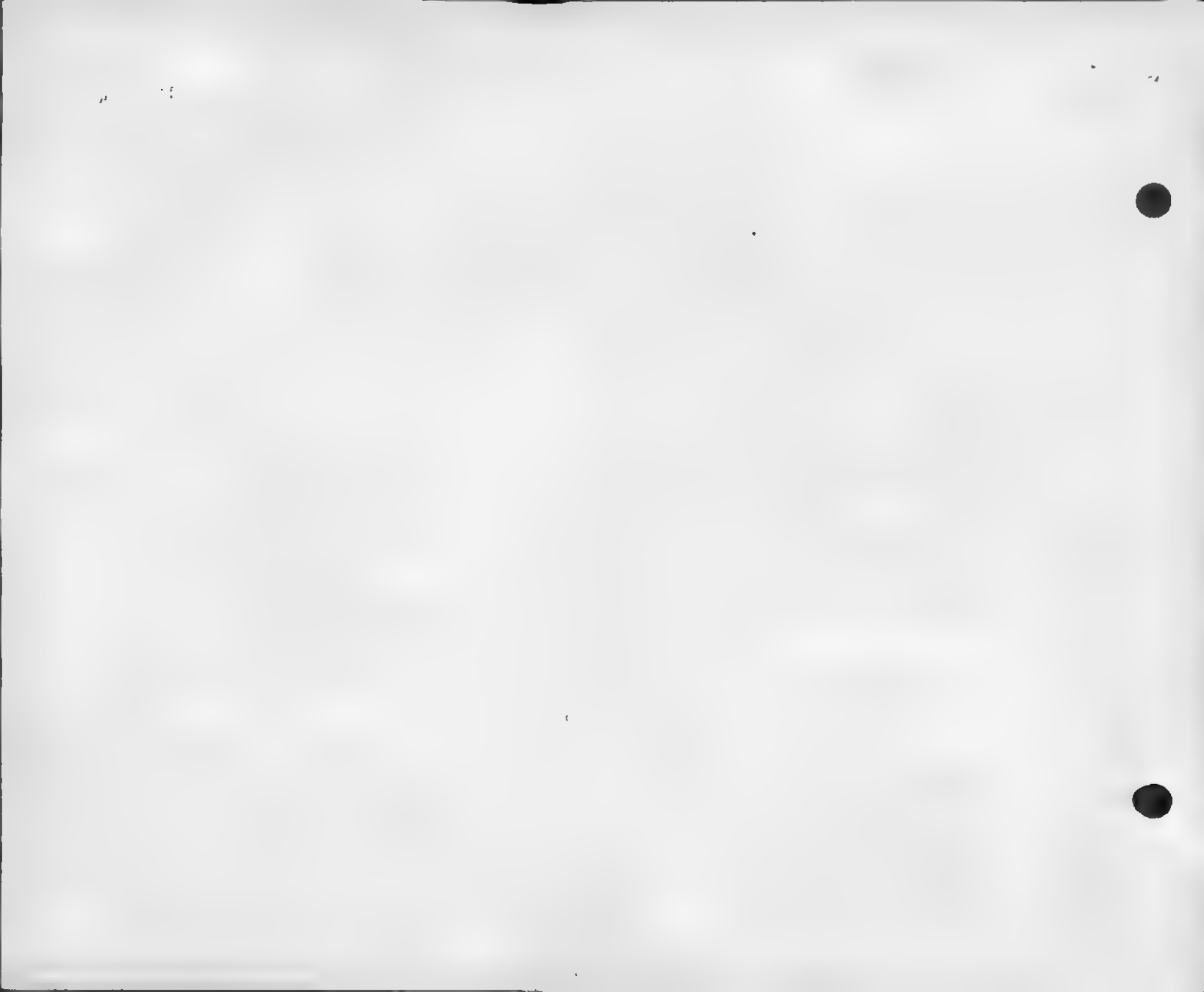
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06902

CERTIFICATE OF DEATH

06887

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a STATE <u>Florida</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY in 1b <u>24 Days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e STREET ADDRESS <u>Route #1, Box 415B</u>	
3 NAME OF DECEASED (Type or print) <u>Foster Lockwood Jones</u>		4 DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4 February 1907</u>
9 AGE (In years lost birthday) <u>60</u> yrs		10 IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>57</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	
11 BIRTHPLACE (County & State or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>William A. Jones</u>		14 MOTHER'S MAIDEN NAME <u>Asenath Lockwood</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>136-09-0988</u>	
17 INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic heart disease with mitral, aortic and tricuspid valve involvement</u> DUE TO (c) <u>tricuspid valve involvement</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF DEATH Month, Day, Year Hour <u>am</u> <u>19</u> p.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <u>18 April</u> , 19 <u>67</u> to <u>12 May</u> , 19 <u>67</u> that (B) (we) last saw the deceased alive on <u>12 May</u> , 19 <u>67</u> , and that death occurred at <u>8:45</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Charles J. Glueck</u>		22b DATE SIGNED <u>13 May 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Charles J. Glueck, MD</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Transit</u>		23b DATE THEREOF <u>5/14/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Sarasota Crematorium</u>		23d LOCATION (City or Town) (County) (State) <u>Sarasota, Florida</u>	
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a REC'D BY REGISTRAR <u>May 16 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation or removal and in only event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06888

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived for at least 1 year before death) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b none		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospt.				d. STREET ADDRESS 10108 Quinby Rd.	
3 NAME OF DECEASED (Type or print) Ira		First Middle Last Harold Kaplan		4 DATE OF DEATH Month Day Year 5 20 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/24/22	9 AGE in years (last birthday) 45 yrs	IF UNDER 1 YEAR Months Days Hours Min 15
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing Co.		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
13. FATHER'S NAME Samuel Kaplan Jr.			14. MOTHER'S MAIDEN NAME Bertha Freedman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOC. A. SECURITY NO.		17. INFORMANT Address Dr. Bonifant Candy Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right Coronary Thrombosis DUE TO (b) with Infarction, left posterior ventricular wall due to Coronary Artery Heart Disease. DUE TO (c) with Infarction, left posterior ventricular wall due to Coronary Artery Heart Disease.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS A DEATH REPORTED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/20/1967	
EXAMINER'S NAME (Type) William R. Keap		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, County, State) 3501-14th St. NW, Wash. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cem.	23d. LOCATION (City or town) (County) (State) Oxon Hill, Maryland	24. FUNERAL DIRECTOR Bernard Danzansky and Sons, NW, Wash. DC	
25a. REG. BY REG. STRAR MAY 24 1967			25b. REGISTRAR'S SIGNATURE [Signature]		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward pending in person Item 18. Give Pages 1, 2, and 3 to the funeral director. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. It may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06889

PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Rockville</u>		USUAL RESIDENCE (Where decedent lived before death) a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Rockville</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASIA SAN + Hosp -</u>		d. STREET ADDRESS <u>8009 14th AVE</u>	
NAME OF DECEASED First <u>Felix</u> Middle <u>W</u> Last <u>KAZANSKI</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-80</u>
9. Aged last birthday <u>87</u>		10. BIRTHPLACE (State or foreign country) <u>POLAND</u>	11. WHAT COUNTRY <u>USA</u>
12. FATHER'S NAME <u>UNK KAZANSKI</u>		13. MOTHER'S M A DEN NAME <u>UNK</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		15. SOCIAL SECURITY NO. <u>UNK</u>	
16. INFORMANT <u>(Son) - Edmund KAZANSKI</u>		Address <u>SA</u>	
17. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO <u>due to Arteriosclerotic Heart Disease</u> DUE TO <u>Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS (CONTINUED) (Not related to the terminal disease condition given in Part I) <u>Coronary atherosclerosis</u>			
18. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20a. DEATH BECAME NERVOUSLY OCCURRED (Enter nature of injury in Part I, if it is a result of injury) 20b. NERVOUSLY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, factory, street, office, etc.) 20d. CITY OR TOWN			
21. I certify that I took charge of the remains described above held in Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>5/20/1967</u>		23. DATE OF BURIAL, CREMATION, REMOVAL (Specify) <u>May 23, 1967</u>	
24. FUNERAL DIRECTOR <u>W. L. Attenuk 3603 14th St NW</u>		25. RECEIVED BY REG. CLERK <u>St Mary's</u> DATE <u>MAY 22 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06905

06890

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>				c LENGTH OF STAY IN 1b <u>7 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp. etc., give street address) <u>Washington Sanitarium & Hospital</u>				e STREET ADDRESS <u>22 Sherman Ave.</u>			
f NAME OF DECEASED (Type or print) First <u>FOREST</u> Middle <u>EUGENE</u> Last <u>KEGG</u>				4 DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1967</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>wh.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-6-1900</u>		9 AGE (In years lost birthday) <u>66</u> yrs	10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hrs <u> </u> Min <u> </u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>			12 KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		13 BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>
15 FATHER'S NAME <u>James H. Kegg</u>				16 MOTHER'S MAIDEN NAME <u>Mary McElley</u>			
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				18 SOCIAL SECURITY NO. <u> </u>			
19 INFORMANT <u>Hospital Records</u>				Address <u> </u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> DUE TO <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic Bronchitis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Arteriosclerosis</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ALICIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20 TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20a INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f (City or town) <u> </u>				20g (County) <u> </u>		20h (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>4-25</u> , 1967, to <u>5-2</u> , 1967, that (I) (we) last saw the deceased alive on <u>5-2</u> , 1967, and that death occurred at <u>10:30</u> M, from causes and on the date stated above							
22a SIGNATURE <u>Thomas P. Fogarty</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>May 6 7</u>	
22c PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>				22d ADDRESS <u>1011 Univ Blvd E Silver Sp Md</u>			
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>May 5, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d LOCATION (City or town) (County) (State) <u>Adelphi P. Geo Co Md</u>	
24 FUNERAL DIRECTOR <u>Arthur Walters</u>				ADDRESS <u>254 Laurel St</u>		25a REC'D BY REGISTRAR <u> </u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>MAY 8 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06906

CERTIFICATE OF DEATH

06891

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>AMY K. KING</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-1-67</u>
9 AGE (If years lost birthday) yrs <u>1</u>		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11 BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Donald King</u>		14. MOTHER'S MAIDEN NAME <u>Martha T. Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Donald King - 9th #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Failure</u> DUE TO (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>Manifested by inter ventricular septal defect</u> <u>Bilateral Lobar Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>April 1, 1967</u> , to <u>May 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 14 1967</u> , and that death occurred at <u>12:44 P.M.</u> , from causes and on the date stated above			
22a SIGNATURE <u>Alan D. Coleman M.D.</u>		22b DATE SIGNED <u>5/20/67</u>	
22c PHYSICIAN'S NAME (Type) <u>ALAN D. COLEMAN M.D.</u>		22d ADDRESS <u>1331 Rockville Pike, Rockville, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/22/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a REC'D BY REGISTRAR <u>Phyllis N. Jones, Jr. D.D. No. 1</u>	
25b REGISTRAR'S SIGNATURE <u>Phyllis N. Jones, Jr.</u>		DATE <u>MAY 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06907

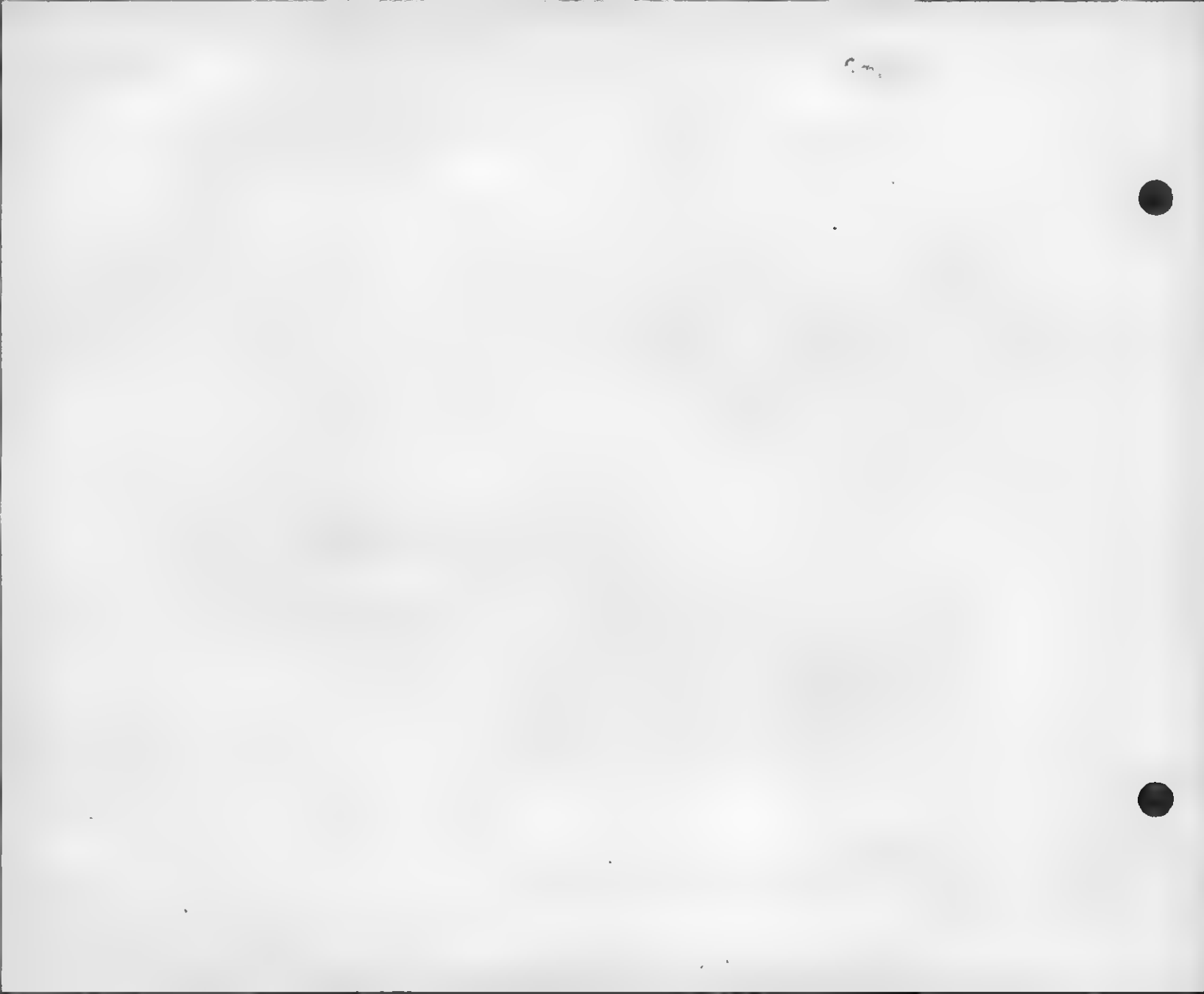
CERTIFICATE OF DEATH

06892

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY N b 18 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d STREET ADDRESS 111 Lafayette Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Anne Gordon KING			4 DATE OF DEATH Month May Day 23 Year 19 67		
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 6, 1888	9 AGE (In years as of birthday) yrs 78	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY N/A	11 BIRTHPLACE (Country & State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME James Price Winchester			14 MOTHER'S MAIDEN NAME Elizabeth McComb		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 559 14 4489	17 INFORMANT Ave., Alexandria Address Virginia RADM Thomas Starr King, Jr. 308 Kentucky		
18 CAUSE OF DEATH (Enter on y one cause per Part I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) Severe arteriosclerotic hypertensive cardiovascular disease DUE TO (c) Severe arteriosclerotic hypertensive cardiovascular disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MED. CAL. EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21 I certify that (this hospital) attended the deceased from May 5 , 19 67 , to May 23 , 19 67 , that (he) (we) last saw the deceased alive on May 23 , 19 67 , and that death occurred at 4:30 A.M. , from causes and on the date stated above.					
22a SIGNATURE <i>Van N. Polglase</i>			22b DATE SIGNED May 24, 1967		
22c PHYSICIAN'S NAME (Type) Van N. Polglase, M.D.			22d ADDRESS Naval Hospital, Bethesda, Md.		
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5-26-67	23c NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery	23d LOCATION (City or Town) (County) (State) Annapolis, Md.		
24 FUNERAL DIRECTOR Joseph Gawler & Sons 5130 Wisconsin Ave. N.W. Washington, D. C.			25a REC'D BY REGISTRAR MAY 23 1967		
			25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal (and any other event, with in 72 hours after death).



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 11/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2 USUAL RESIDENCE (Where deceased lived, if institut c. Residence before address on) a STATE Maryland b COUNTY Montgomery	
c LENGTH OF STAY IN 1b 2 days/13 hours		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		e STREET ADDRESS 7405 Jackson Ave.	
3 NAME OF DECEASED (Type or print) First Clara Middle Louise Last Kirchgeßner		4 DATE OF DEATH Month May Day 23 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 28, 1891
9 AGE (In years last birthday) 76		10 UNDER 24 HRS Months 12 Days 23 Hours 13 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY At Home	
11 BIRTHPLACE (County & State, or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Louis Franke		14 MOTHER'S M A D E N NAME Louise Haneke	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ice) No		16 SOCIAL SECURITY NO 579-28-8463	
17 INFORMANT Hospital Records		Address 7600 Carroll Ave.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Arteriosclerotic and atherosclerotic changes CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost unknown (c)			INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			19 WA A T O P S Y PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from May 22, 1967 to May 23, 1967 , that (I) (we) last saw the deceased alive on May 22, 1967 , and that death occurred at 5:14 A.M. , from causes and on the date stated above			
22a SIGNATURE Francis Macell		22b DATE SIGNED May 24, 1967	
22c PHYSICIAN'S NAME (Type) Francis Macell		22d ADDRESS 254 Carroll St. N.W.	
23a BURIAL CREMATION OR REMOVAL (Specify) Burial	23b DATE THEREOF May 26-1967	23c NAME OF CEMETERY OR CREMATORY Green Hill Cemetery, Suitland, Prince Georges Co. Md.	23d LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR William Walters		25a REC'D BY REGISTRAR May 24 1967	25b REGISTRAR'S SIGNATURE W. Walters



CERTIFICATE OF DEATH

36903

06894

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY MONTG.			
b. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 1/2 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				e. STREET ADDRESS 11801 PITTSBORO RD.			
3 NAME OF DECEASED (Type or print) HENRY Godfrey KIRSCHENMANN				4 DATE OF DEATH Month 5 Day 27 Year 1967			
5 SEX M	6 CO. OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-10-92	9 AGE (In years last birthday) 74 yrs	F UNDER 1 YEAR Months Days		F UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Butcher				10b. KIND OF BUSINESS OR INDUSTRY Meat Market		11 BIRTHPLACE (County & State or foreign country) New York	
13 FATHER'S NAME Louis Kirschenmann				14 MOTHER'S MAIDEN NAME Justina Do			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WWI				16 SOCIAL SECURITY NO. 132-10-4838		17 INFORMANT Helen Kirschenmann Address 11801 Pittsboro Rd. Wheaton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Myocardial Infarct OUE TO (c) Advanced arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1966 to 5/27 , 19 67 , that (I) (we) last saw the deceased alive on 5/27 , 19 67 , and that death occurred at 12-10 M, from causes and on the date stated above							
22a. SIGNATURE Richard Delaney				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED May 28, 1967	
22c. PHYSICIAN'S NAME (Type) Richard Delaney				22d. ADDRESS 4323 Harvard St., S. S., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24 FUNERAL DIRECTOR Warner E. Purphrey, Inc.				25a. REC'D BY REG. STRAR Clark E. Waga		25b. REGISTRAR'S SIGNATURE Clark E. Waga	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and interment within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06910

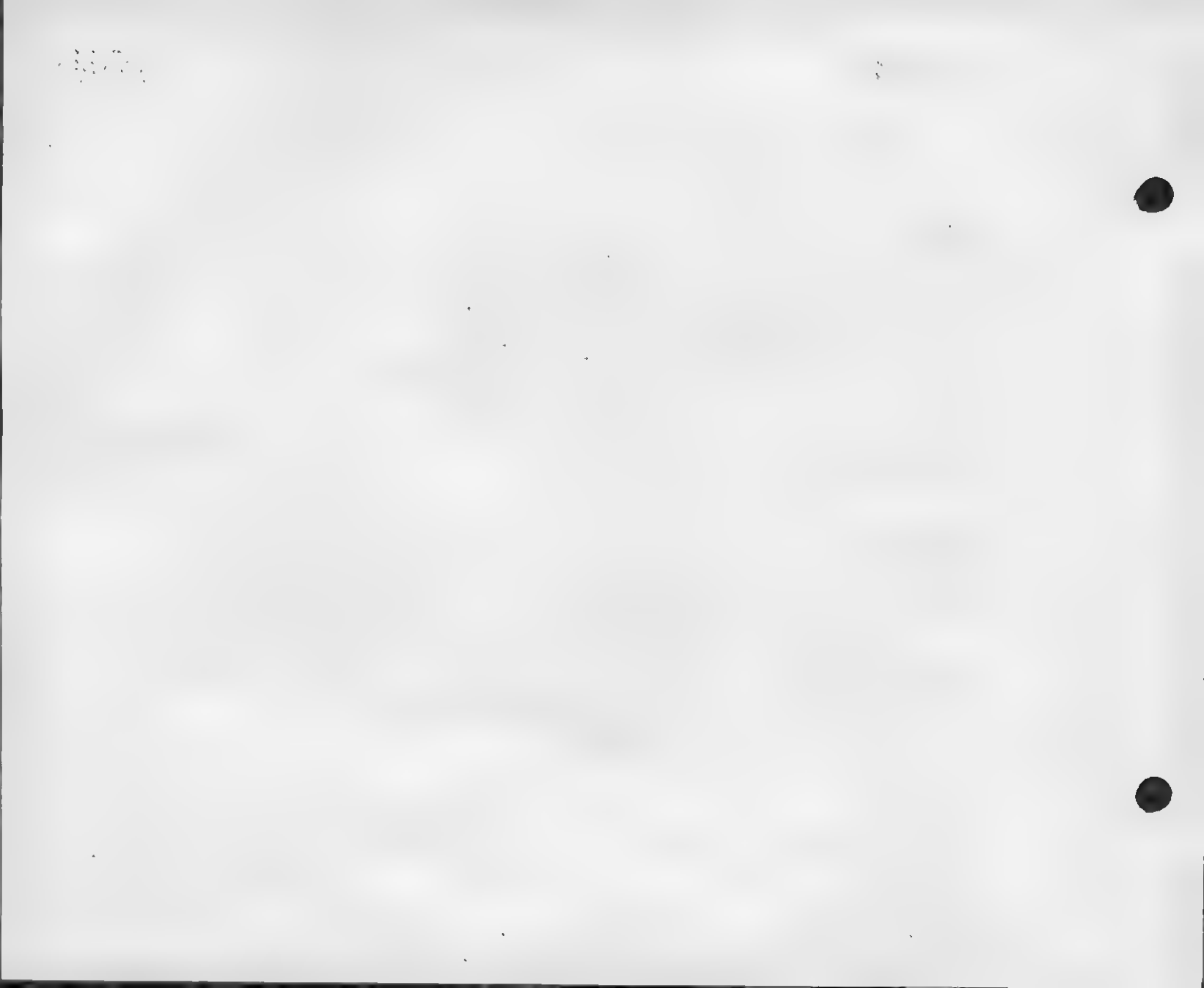
CERTIFICATE OF DEATH

06895

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If patient in hospital give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2702 Harmon Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>WALTER</u> Last <u>KLOCKENBRINK</u>		4 DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/1/24</u>
9a. AGE (In years and months) <u>42</u> YRS		9b. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <u>5</u> Days <u>21</u> Hours <u>00</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corp. Addressograph - Multiplier</u>	
11 BIRTHPLACE (County & State or foreign country) <u>PA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Fred A. Klockenbrink</u>		14 MOTHER'S MAIDEN NAME <u>Julia Zblewski</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16 SOCIAL SECURITY NO <u>577-10-3720</u>	
17. INFORMANT <u>Mrs. Hilda Klockenbrink</u>		Address <u>2702 Harmon Rd. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Carcinoma - Colon - (Ulcer)</u>			
DUE TO			
(b) <u>Chronic</u>			
DUE TO			
(c) <u>Fracture, Pneumonia</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>May 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 20</u> , 19 <u>67</u> , and that death occurred at <u>2:40</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>George Sharp</u>		22b DATE SIGNED <u>May 21, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>George Sharp</u>		22d ADDRESS <u>10400 Conn. Ave., Kensington, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 23, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>MAY 21 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

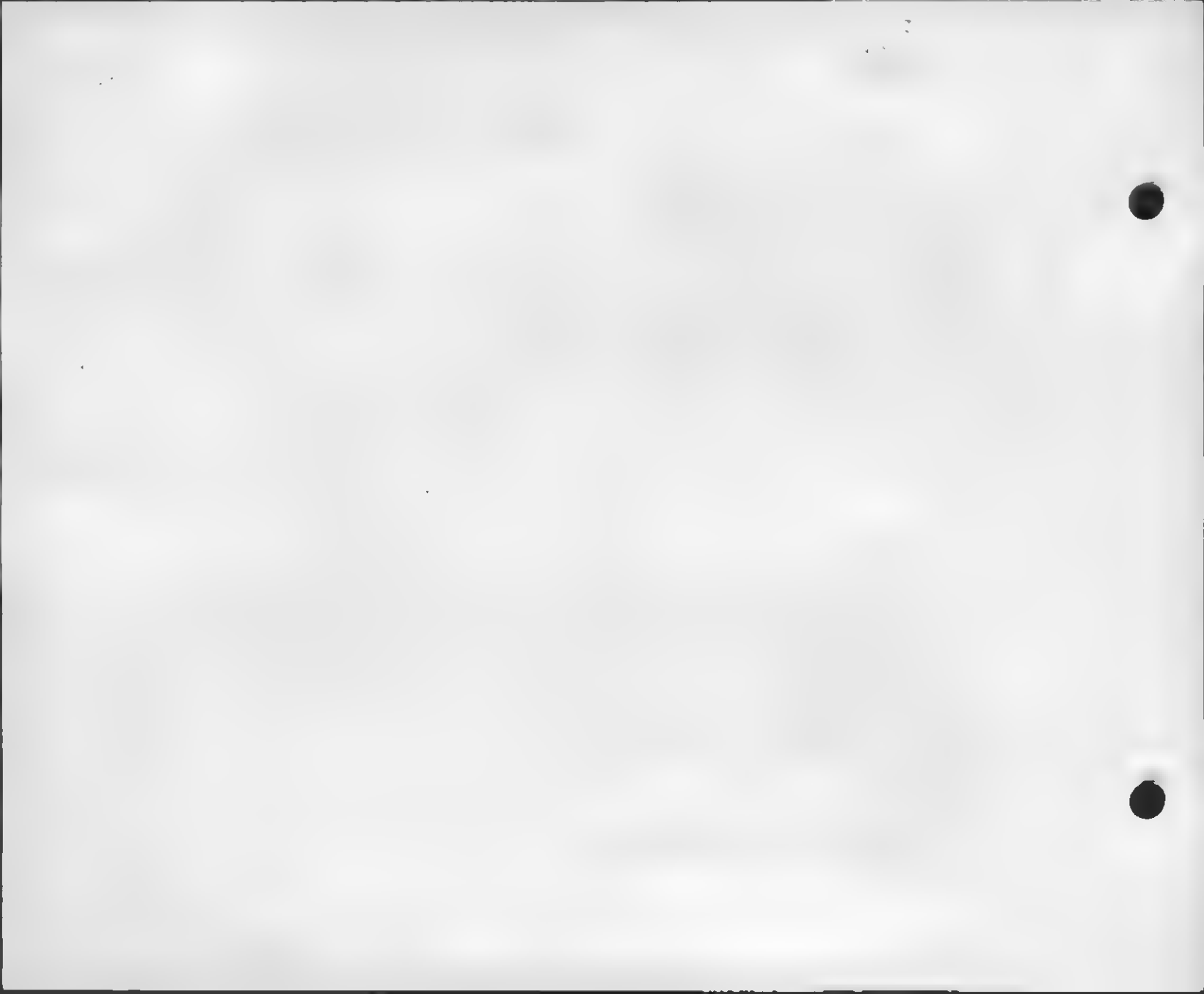
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06911

CERTIFICATE OF DEATH

06896

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montgomery c LENGTH OF STAY IN TB 10000000000			2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Florida b COUNTY Dade c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunedin		
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Hospital			d STREET ADDRESS 612 N. 1st St.		
4 NAME OF DECEASED (Type or print) First Middle Last Nils P. Larsen			5 DATE OF DEATH Month MAY Day 25 Year 1967		
6 SEX M	7 COLOR OR RACE W	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 DATE OF BIRTH 5-8-87	10 AGE (In years lost birthday) 80 yrs	11 GENDER YEAR IF UNDER 24 HRS Months Days Hours Min
12a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY INDUSTRY		
13 FATHER'S NAME Nils P. Larsen			14 MOTHER'S MAIDEN NAME Hilda Johnson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 340-12-2344			16 SOCIAL SECURITY NO 340-12-2344		
17 INFORMANT Donna			Address 4119 Barnaby St.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis generalized					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Infection (Pneumonia)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)			
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f City or town	20g County	20h State
21 I certify that (I) (this hospital) attended the deceased from April 15, 1967 to July 25, 1967 that (I) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:45 AM from causes and on the date stated above					
22a SIGNATURE Frederick P. Chapman 22c PHYSICIAN'S NAME (Type) 1234 - 19th St. NW			22b DATE SIGNED May 25/67		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE THEREOF		
23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) County, State		
24 FUNERAL DIRECTOR S.H. HINES CO.			25a REC'D BY REGISTRAR MAY 26 1967		
25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tab, papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06912

CERTIFICATE OF DEATH

06897

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kennel's 2100 N. 4th St.</i>		e. STREET ADDRESS <i>12103 Charles Road</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>ETHEL E. LATHERS</i>		4 DATE OF DEATH Month Day Year <i>May 25, 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/86</i>
9. AGE in years Months Days Hours Min <i>81</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <i>Bristol, England</i>		12. CITIZENSHIP OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Parson</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Briggs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>095-20-3131</i>	
17. INFORMANT <i>S. Elaine Belanger- Item # 2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>12 HRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Bronchitis, Malnutrition</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>7/1</i> , 19 <i>62</i> , to <i>5/25</i> , 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5/25</i> , 19 <i>65</i> , and that death occurred at <i>3 P.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Raymond T. Binnick MD</i>		22b. DATE SIGNED <i>5/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Raymond T. Binnick MD</i>		22d. ADDRESS <i>4415 Colebrook Lane, Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/29/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville</i>	23d. LOCATION (City or town) (County) (State) <i>Rockville, Md.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville</i>		25. REC'D BY REGISTRAR <i>Pike</i> DATE <i>29 1967</i>	
ADDRESS <i>Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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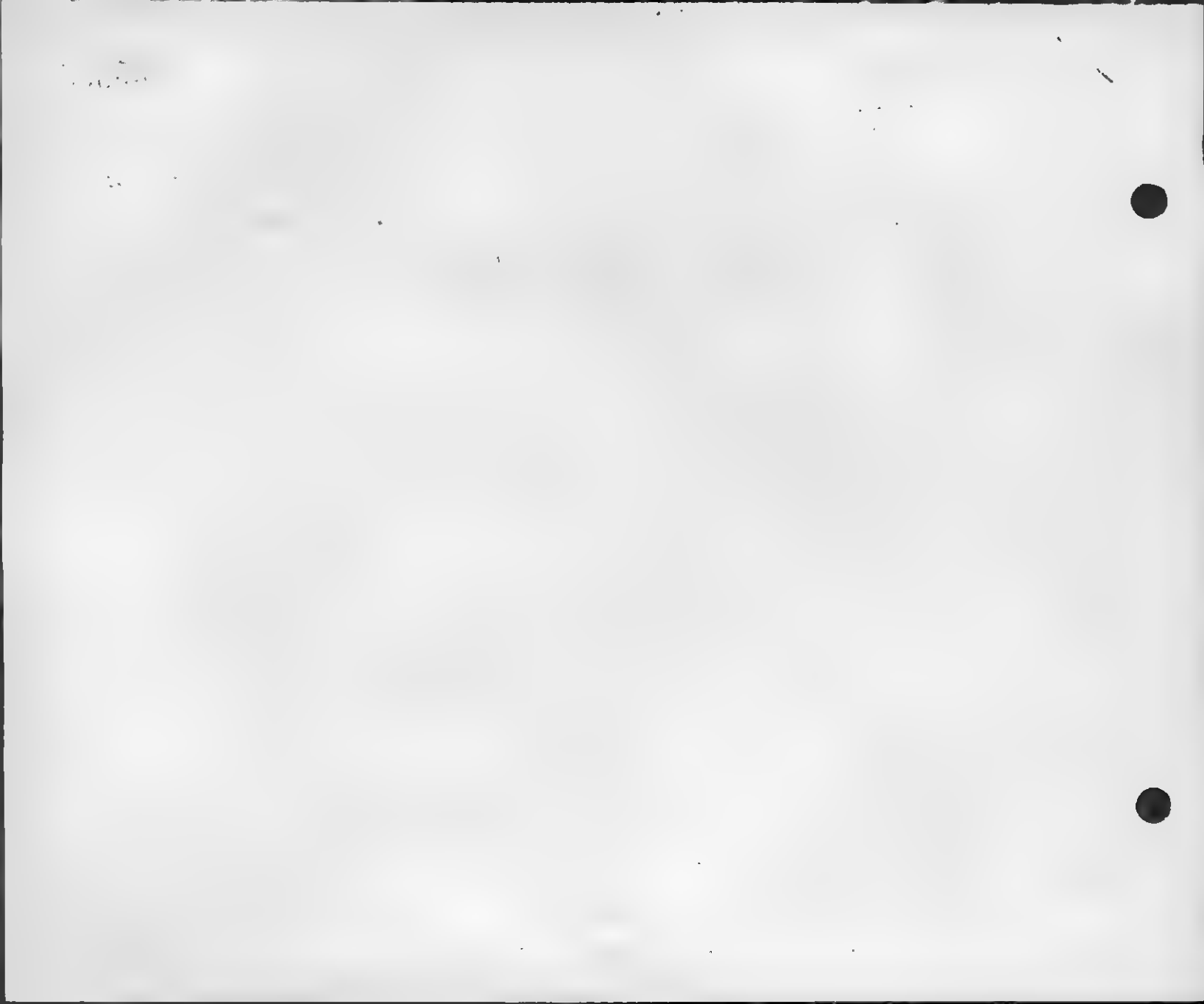
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6913

05898

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN ID <u>2 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY <u>Tulsa</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tulsa</u> d. STREET ADDRESS <u>1138 S. Wheeling</u>			
3. NAME OF DECEASED (Type or print) <u>NOLIE Grace Laughlin</u> First Middle Last		4. DATE OF DEATH <u>5 - 21 19 67</u> Month Day Year		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/82</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ti. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James M. Nolan</u>				14. MOTHER'S MAIDEN NAME <u>Grace G. Laughlin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N</u>		16. SOCIAL SECURITY NO. <u>441 34-7854</u>		17. INFORMANT <u>Margaret H.</u>		Address <u>2002</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis - Cardiac</u> DUE TO (b) <u>Compensated Heart Failure Due to Cirrhosis</u> DUE TO (c) <u>Chronic Alcoholism</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2-8</u> <u>19.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> to <u>May 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James E. Nolan</u>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. NOLAN</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>5411 N. ...</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG. STRAR <u>MAY 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

068914

06899

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Dade			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY # 1b 74 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Miami	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 13205 Coronado Drive		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Harless LAWSON				4. DATE OF DEATH Month Day Year May 10 1967			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 1912		9. AGE (in years last birthday) 54 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy-Civil Service			10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Ewell LAWSON				14. MOTHER'S MAIDEN NAME Nellie Gertrude Fleming			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes			16. SOCIAL SECURITY NO 227-60-1102		17. INFORMANT Address 13205 Coronado Dr., N. Miami, Fla. Mrs. Carolyn M. Lawson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the rectum with widespread metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN DEATH AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from Feb. 26 , 19 67 to May 10 , 19 67 , that (b) (we) last saw the deceased alive on May 10 , 19 67 , and that death occurred at 120A M, from causes and on the date stated above.							
22a. SIGNATURE <i>William R. Hix</i>				22b. DATE SIGNED 10 May 1967		22c. PHYSICIAN'S NAME (Type) William R. Hix, M.D.	
22d. ADDRESS Naval Hospital, Bethesda, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 15-11-1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or town) (County) (State) Miami Florida
24. FUNERAL DIRECTOR Joseph Gawler & Sons				25a. REC'D BY REGISTRAR MAY 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
25c. ADDRESS 5130 Wisconsin Ave., N. W. Washington, D.C.							



TO DEPUTY MEDICAL EXAMINER: The following should be executed within 24 hours after death. If any delay is necessary, please execute the entire list within the word preceding appears in Item 18. Give Pages 1, 2, 3, 13 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: The following should be executed within 24 hours after death. If any delay is necessary, please execute the entire list within the word preceding appears in Item 18. Give Pages 1, 2, 3, 13 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06900

PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		USUAL RESIDENCE (Where death occurred) STATE <u>Md</u> COUNTY <u>Montgomery</u>	
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		CITY OR TOWN (If inside corporate limits write RURAL) <u>Bethesda</u>	
NAME OF DECEASED (If at a hospital give street address) <u>5513 Northfield Rd.</u>		STREET ADDRESS <u>5513 Northfield Rd.</u>	
NAME OF DECEASED First <u>Ethel</u> Middle <u>Rice</u> Last <u>Le. Carpentier</u>	DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1967</u>	DATE OF BIRTH Month <u>Oct</u> Day <u>18</u> Year <u>1888</u>	
SEX <u>Fe</u> COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
OCCUPATION (If work done at home, give nature of work) <u>HOUSEWIFE</u>		INDUSTRY <u>U.S.A</u>	
FATHER'S NAME <u>Edward Vincent Rice</u>		MOTHER'S MAIDEN NAME <u>Laura Prosperi (Rice)</u>	
WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		SOCIAL SECURITY NO. <u>579-60-7646</u>	
INFORMANT <u>Daughter Christine Gross</u>		ADDRESS <u>Washington DC</u>	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>Sudden</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <u>Years</u>	
INTERNAL A CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		DESCRIBE HOW INJURY OCCURRED (Enter nature of injury. Part of Part 4 of form)	
TIME OF INJURY (Month, Day, Year) Hour a.m. <u>19</u> p.m. <u>19</u>		PLACE OF INJURY (factory, street, office bldg, etc.)	
I certify that I took charge of the body described above, held an Autopsy <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Other <input type="checkbox"/>		CHIEF MEDICAL EXAMINER NAME <u>John W. Ball</u> M.D. DATE <u>5/7/67</u> Address (Street, city, town, or county)	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		22 DATE SIGNED	
BURIAL <u>5-10-67</u>		MT OLIVET CEMETERY WASHINGTON D.C.	
F. J. COLLINS		MAY 10 1967, Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06916

06901

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b. 16 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timory Grove d. STREET ADDRESS Timory Grove e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Flzie Middle Edward Last Lee		4 DATE OF DEATH Month May Day 4 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-2-01
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years past birthday) 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) Maryland
12 COUNTRY OF BIRTH USA		13 FATHER'S NAME Fred Jackson	
14 MOTHER'S MAIDEN NAME Bessie Lee		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Montgomery Gen. Hospital Olney, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) spontaneous, hemorrhagic DUE TO (b) arterio-sclerotic cardiovascular disease DUE TO (c) last			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. CITY OR TOWN Olney, Md.
21 I certify that (I) (the hospital) attended the deceased from 8/22, 1967 to 5/4, 1967 that (I) (we) last saw the deceased alive on 5/3, 1967 , and that death occurred at 12:20 AM from causes and on the date stated above			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED 5-15/67	
22c. PHYSICIAN'S NAME (Type) A. D. Bonifant		22d. ADDRESS 5444 Sandy Spring Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Knox Oak Cemetery		23d. LOCATION (City or town) Spencer, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden		25a. READ BY REGISTRAR Knoxville, Md.	
25b. REGISTRAR'S SIGNATURE John L. Judge		25c. DATE MAY 11 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06917

06902

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>35 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Eula Catherine Lee</u>		4 DATE OF DEATH Month Day Year <u>May 11 19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>26 January 1920</u>
9 AGE (in year, last birthday) <u>47</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min <u>26</u> <u>11</u> <u>19</u> <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmus A. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Nancy L. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>265-12-1075</u>	
17 INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral pneumonia secondary to E. coli septicemia</u> DUE TO (b) <u>Cardiovascular collapse</u> DUE TO (c) <u>Blastic crisis - myelogenous leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 days</u> <u>32 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (A) (th/s hospita) attended the deceased from <u>6 April</u> , 19 <u>67</u> , to <u>11 May</u> , 19 <u>67</u> , that (A) (we) last saw the deceased alive on <u>11 May</u> , 19 <u>67</u> , and that death occurred at <u>2:00M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. Kierney</u>		22b. DATE SIGNED <u>11 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carl E. Kierney, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City or Town) (County) (State)		23e. RECORD BY REGISTRAR <u>MAY 15 1967</u>	
24. FUNERAL DIRECTOR		25b. REGISTRAR'S SIGNATURE <u>Johnnie Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event within 72 hours after death.

100

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

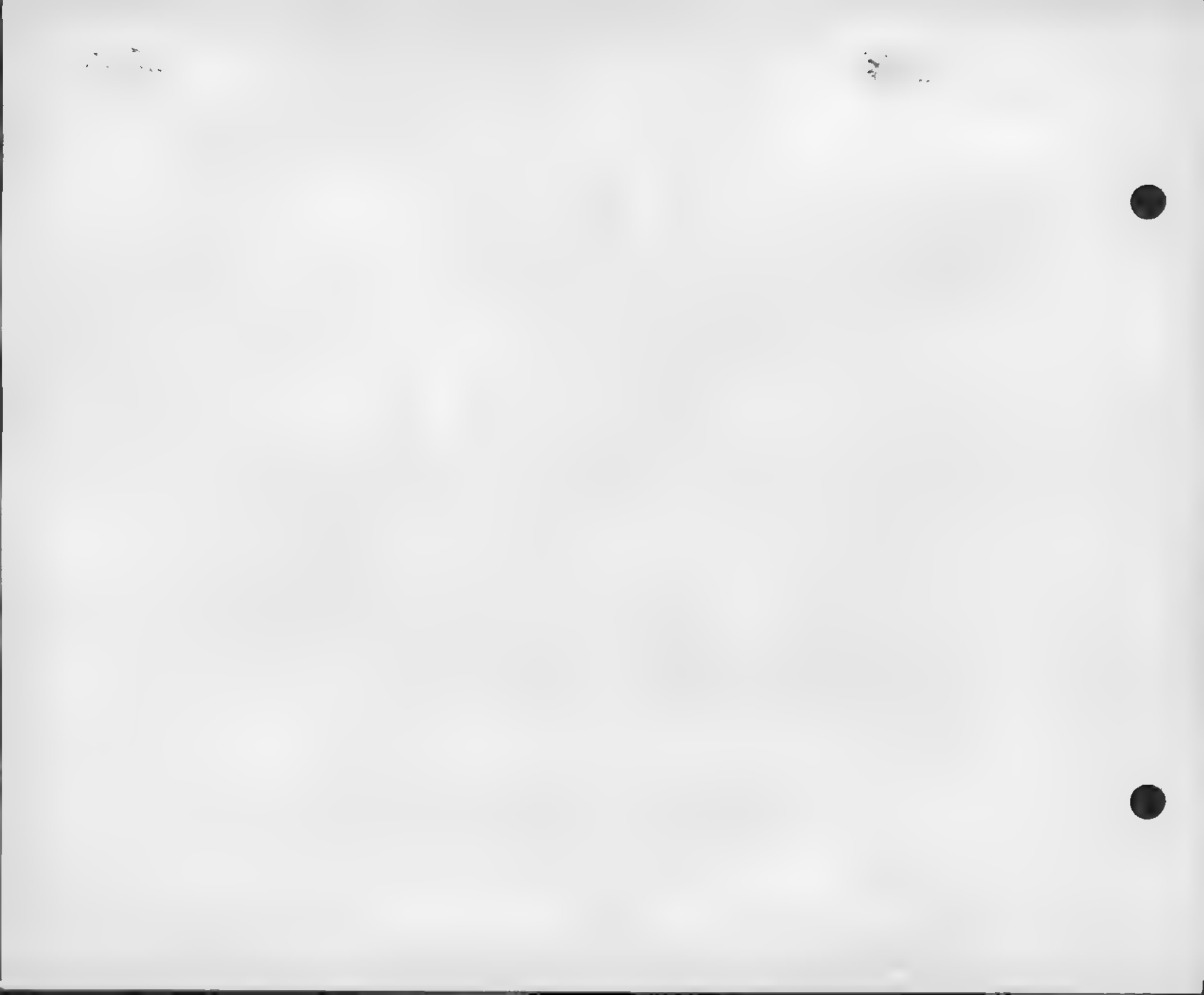
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06918

CERTIFICATE OF DEATH

06903

1 PLACE OF DEATH a COUNTY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN b		2 USUAL RESIDENCE (Where deceased lived, if not institution; Residence before admission) a STATE b COUNTY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last		4 DATE OF DEATH Month Day Year	
5 SEX	6 COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 AGE (in years, lost birthday) F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT		Address	
B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30-60 HS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1964 to May 27, 1967 that (I) (we) last saw the deceased alive on May 27, 1967, and that death occurred at 1130P M, from causes and on the date stated above			
22a SIGNATURE Hugo G. Graziani, M.D. John Core for Dr. Brandes (Adolph, M.D.) M.D.		22b DATE SIGNED 5/28/67	
22c PHYSICIAN'S NAME (Type) Hugo G. Graziani, M.D.		22d ADDRESS 10101 Georgia Ave. Silver Sp Md	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City & Town) (County) (State)	
24 FUNERAL DIRECTOR Will Chambers - Riverdale, MD.		25a REC'D BY REGISTRAR JUN 1 1967	
		25b REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06919

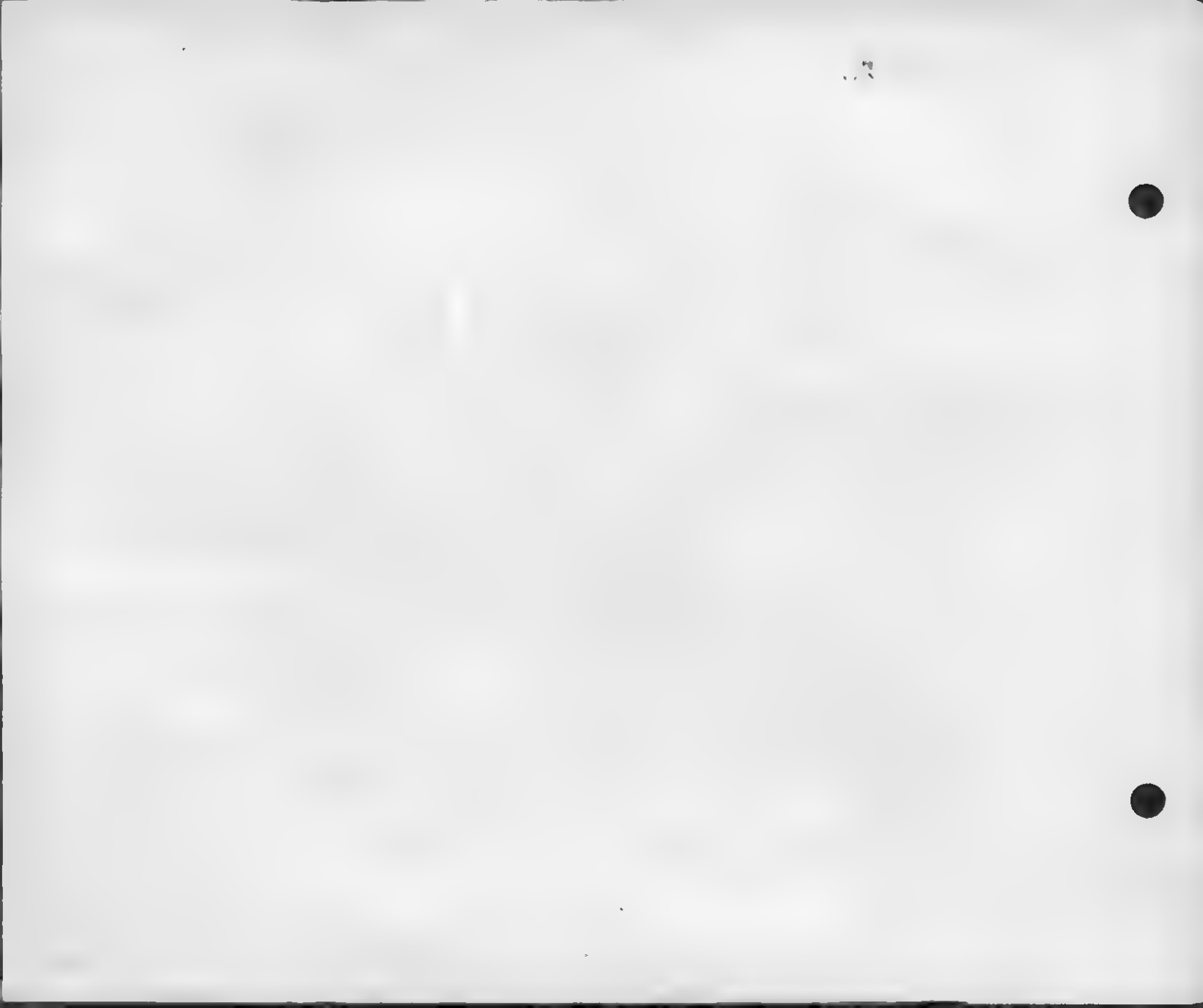
CERTIFICATE OF DEATH

06904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Maryland</u>				2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seatonsville</u>		c LENGTH OF STAY IN (In) <u>4-6-17</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seatonsville</u>			
d OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Seatonsville</u>				d STREET ADDRESS <u>4504-5th Avenue SE</u>		e IS RESIDENCE "ON A FARM?" YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Levinson</u> Last <u>Levinson</u>				4 DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-17-22</u>	9 AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	IF UNDER 24 HRS Hours <u>17</u> Min <u>00</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11 AGE (If born in State or foreign country) <u>35</u>		12 COUNTRY OF BIRTH <u>USA</u>	
13 FATHER'S NAME <u>ZUNDEL LEVINSON</u>				14 MOTHER'S MARDEN NAME <u>DEBORAH</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>1-11-11</u>		17 INFORMANT <u>Deborah Levinson</u> Address <u>Seatonsville</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Coronary heart disease</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Name form factory street office blog etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>January 1962</u> to <u>May 1967</u> that (I) found last saw the deceased alive on <u>April 1967</u> , and that death occurred at <u>6:30 p.m.</u> from causes and on the date stated above.							
22a SIGNATURE <u>Gilbert Hurwitz</u>				22b DATE SIGNED <u>May 7 67</u>		22c PHYSICIAN'S NAME (Type) <u>Gilbert Hurwitz</u>	
22d ADDRESS <u>1800 Eye St. N.W. Wash DC 20006</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>5/9/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Hyattsville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>				ADDRESS <u>3501-14th St. NW, Wash. DC</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>MAY 11 1967</u>		25b REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

06920

06905

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>SILVER SPRING</u>	
g NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>HOLY CROSS HOSPITAL</u>		d STREET ADDRESS <u>1717 Albuti DRIVE</u>	
NAME OF DECEASED (Type or print) <u>MANUS — LEWITZ</u>		4 DATE OF DEATH <u>5 22 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>POLISH</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-21-06</u>
9 AGE (n years last birthday) <u>61 yrs</u>		10 IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (County & State or foreign country) <u>POLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>SAMUEL LEWITZ</u>		14 MOTHER'S MAIDEN NAME <u>MENDEL</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour am pm 19 <u>67</u>	20d INJURY OCCURRED Where <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1958</u> to <u>May 22 1967</u> that (I) (we) last saw the deceased alive on <u>May 22 1967</u> and that death occurred at <u>9:30 PM</u> from causes and on the date stated above			
22a SIGNATURE <u>John J. Curry</u>		22b DATE SIGNED <u>May 22 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		22d ADDRESS <u>16620 Georgetown Rd Silver Spring</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>5-24-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>ELLSAVETGRAD CEMETERY</u>	23d LOCATION (City or town) (County) (State) <u>WASHINGTON DC</u>
24 FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS</u>		25a REC'D BY REGISTRAR <u>DATE MAY 25 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>not work. Juss.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06921

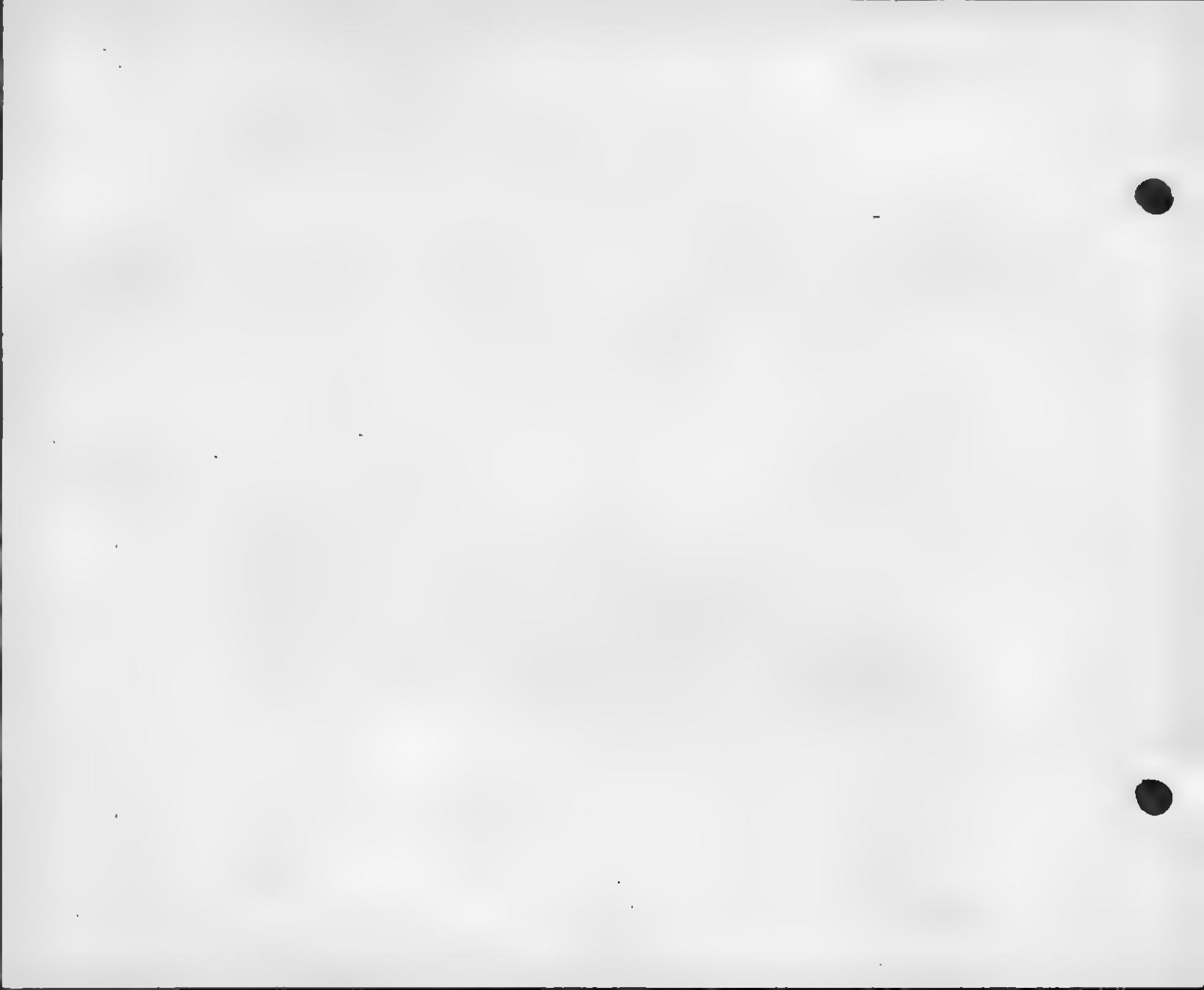
CERTIFICATE OF DEATH

06906

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f Institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b 30 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Carl Middle Axel Last Lind		4 DATE OF DEATH Month 5 Day 5 Year 19 57	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/8/79
9 AGE (in years last birthday) 37 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
10b KIND OF BUSINESS OR INDUSTRY Worthington Pump Co.		11 BIRTHPLACE (County & State or foreign country) Sweden	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Axel Alfred Lind	
14 MOTHER'S MAIDEN NAME Johanna Christina Lind		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16 SOCIAL SECURITY NO 136-37-5657		17 INFORMANT Dr. S. S. Rich Address 10000 Ave. Hospital Records, Olney, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Uremia DUE TO Hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-5-57 to 5-5-57 , that (I) (we) lost 11:40 PM from causes on and on the date stated above.			
22a SIGNATURE C. H. L. 1967		22b DATE SIGNED 5/6/67	
22c PHYSICIAN'S NAME (Type) C. H. L. 1967		22d ADDRESS Sandy Spring Md	
23a BURIAL, CREMATION, REMAINS (Specify)	23b DATE THEREOF May 8, 1967	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	23d LOCATION (City or town) (County) (State) Prince Georges Co., Md.
24 FUNERAL DIRECTOR C. H. L. 1967		25a REC'D BY REGISTRAR MAY 11 1967	
25b REGISTRAR'S SIGNATURE John C. Finamore, Inc.		25c REGISTRAR'S SIGNATURE John C. Finamore, Inc.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00922

CERTIFICATE OF DEATH

06907

1. PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring</u>				c LENGTH OF STAY in 1b <u>5 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's Hospital</u>				d STREET ADDRESS <u>1100 N. E. St.</u>			
3. NAME OF DECEASED (Type or print) <u>LOUISE A. LINTHICUM</u> First Middle Last				4. DATE OF DEATH <u>MAY 17 1967</u> Month Day Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-92</u>	9. AGE (in years last birthday) <u>74</u> yrs	F UNDER 1 YEAR Months Days		F UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State or foreign country) <u>Montgomery, Md.</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John L. Linticum</u>				14. MOTHER'S MAIDEN NAME <u>Willie Anna Linticum Lunsden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-32-7097</u>		17. INFORMANT <u>James L. Linticum</u> Address <u>1100 N. E. St.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Chronic Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 19, 1967</u> , to <u>May 17, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>July 16, 1967</u> , and that death occurred at <u>5:10 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John L. Linticum</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>5-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Linticum</u>				22d. ADDRESS <u>1100 N. E. St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>John L. Linticum</u> ADDRESS <u>1100 N. E. St.</u>				25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Linticum</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06923

CERTIFICATE OF DEATH

06908

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Rhode Island b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN Id 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 340 Annanquattucket Road	
3 NAME OF DECEASED (Type or print) First Middle Last Sabine (None) Lioce		4 DATE OF DEATH Month Day Year May 4 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH September 3, 1918
9 AGE (In years lost birthday) 48 yrs		10 F UNDER 1 YEAR Months Days Hours Min 8 1	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic		12 INDUSTRY Airlines	
13 BIRTHPLACE (Country & State or foreign country) Rhode Island		14 CITIZEN OF WHAT COUNTRY? USA	
15 FATHER'S NAME Joseph Lioce		16 MOTHER'S MAIDEN NAME Conchetta Razza	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1940-1962		18 SOCIAL SECURITY NO 035-01-6209	
19 INFORMANT The Medical Record		20 ADDRESS The Clinical Center, Bethesda, Md. 20014	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe calcific aortic valvular stenosis DUE TO (b) Intermittent DUE TO (c) Intermittent			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intermittent			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that XX (this hospital) attended the deceased from May 3 , 19 67 , to May 4 , 19 67 , that XX (we) last saw the deceased alive on May 4 , 19 67 , and that death occurred at 7:30 M. from causes and on the date stated above.			
22a SIGNATURE Alan S. Rosenthal		22b DATE SIGNED 4 May 1967	
22c PHYSICIAN'S NAME (Type) L Alan S. Rosenthal, MD		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL, OR OTHER	23b DATE THEREOF MAY 8/67	23c NAME OF CEMETERY OR CREMATORY ST. ANN'S CEMETERY	23d LOCATION (City or Town) (County) (State) CRANSTON, RHODE ISLAND
24 FUNERAL DIRECTOR MARTIN W HYSONG CO.		25a REC'D BY REGISTRAR 1300 - N ST. N W WASHINGTON, D.C.	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details
of the death are not known, the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 in
the order. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-
5 may be retained for your files
TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26924

06909

1 PLACE OF DEATH a. COUNTY <u>Rockville</u> b. CITY <u>Rockville</u>		USUAL RESIDENCE a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
2 NAME OF DECEASED Type or print <u>Charles Homer Lloyd</u>		3 STREET ADDRESS <u>913 BRANDIN AVE.</u>	
SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4 DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>
10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, e.g., street car driver)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Teacher</u>		<u>Pennsylvania</u>	
3 FATHER'S NAME <u>Abner Lloyd</u>		14 MOTHER'S M maiden name <u>Flick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17 INFORMANT Address <u>Kathryn E. Lloyd- wife same item #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>541.1</u> DUE TO <u>Chronic alcoholism</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (b) <u></u>			
(c) <u></u>			
PART II OTHER SIGNIFICANT CAUSE, IN WHICH DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> pm		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21 I certify that I am a duly qualified and licensed Medical Examiner and I have examined the body of the deceased and the death resulted from <u>Accident</u> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME <u>John P. Rogers</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22 DATE SIGNED <u>5-22-67</u>			
REMOVAL (Specify) <u>burial</u>		24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>	
5/25/67		Gate of Heaven 1331 Rockville Pk. Rockville, Maryland	
		Silver Spring Maryland BY REGISTRAR MAY 24 1967 <u>Charles Judge</u>	

1941

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1943

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death should be filed with the State Dept of Health prior to burial, cremation, or removal.

12

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06925

CERTIFICATE OF DEATH

06910

1 PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived 1 month prior to death or before admission) a STATE <u>MARYLAND</u> b COUNTY <u>ANNE ARUNDEL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e STREET ADDRESS <u>3002 Bluebridge Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>FLORIANE Marie LOFGREN</u>		4 DATE OF DEATH Month Day Year <u>MAY 27 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/7/86</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	10 AGE (in years last birthday) <u>80</u> yrs
11 BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Ernest Sittig</u>		14 MOTHER'S MAIDEN NAME <u>Caroline Krenger</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>579-01-3487 B</u>	
17 INFORMANT <u>Mrs. Robert Arsenault</u>		18 ADDRESS <u>3002 Bluebridge Ave. Wheaton, Md. 20910</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) <u>Cerebral Hemorrhage</u> <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	21b NATURE OF INJURY While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1958</u> to <u>May 27, 1967</u> that (I) (we) last saw the deceased alive on <u>May 27, 1967</u> and that death occurred at <u>2:00 PM</u> from causes and on the date stated above			
22a SIGNATURE <u>John J. Curry</u> M.D.		22b DATE SIGNED <u>5/28/67</u>	
22c PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d ADDRESS <u>10640 Georgia Avenue, Silver Spring, Md.</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>May 31, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>
24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>105</u>	
25b REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06926

CERTIFICATE OF DEATH

06911

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <input checked="" type="checkbox"/> b COUNTY <input checked="" type="checkbox"/>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rockville				c LENGTH OF STAY IN TB			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home				d STREET ADDRESS #537 - 38th. St. N.W.			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) John Thomas Long				4 DATE OF DEATH Month 5 Day 12 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Nov. 7, 1890	
9 AGE (In year - last birthday) 76 yrs		10 IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min 0		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZENSHIP OF WHAT COUNTRY US	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Technician				10b KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME James M. Long				14 MOTHER'S MAIDEN NAME Jane H. Bailey			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 1		16 SOCIAL SECURITY NO 579-60-6910		17 INFORMANT Mrs Julia J. Long - Item # 2			
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute coronary heart failure DUE TO arteriosclerotic heart disease stating the underlying cause last (b) generalized arteriosclerosis (c) generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs 5 yrs 10 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)				19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home form factory, street, office, bldg, etc.)	
20f City or town Rockville County Montgomery State Md							
21 I certify that (I) (this hospital) attended the deceased from Dec 6, 1966 to May 12, 1967 that (I) (we) last saw the deceased alive on 5/12/1967 , and that death occurred at 9 P M , from causes and on the date stated above							
22a SIGNATURE 18 F. Kreuzburg				22b DATE SIGNED 5/12/67			
22c PHYSICIAN'S NAME (Type) 18 F. Kreuzburg				22d ADDRESS 7852 16th Ave. Wash D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/15/67		23c NAME OF CEMETERY OR CREMATORY St. Josephs		23d LOCATION (City or town) (County) (State) Morganza, Maryland	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike				25a REC'D BY REGISTRAR MAY 16 1967		25b REGISTRAR'S SIGNATURE J. M. Jones	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26927

06912

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: The certificate should be executed within 24 hours after death. If any delay is caused by any person executing the certificate, the ward, pending in person, in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department. He then or to burial removal or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b STATE <u>Maryland</u> c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u> c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
3 NAME OF DECEASED (Type or print) <u>Florence Ellen Longo</u> d SEX <u>Female</u> e COLOR <u>White</u>		4 DATE OF DEATH a MONTH <u>5</u> b DAY <u>31</u> c YEAR <u>1967</u>	
5 NAME OF FATHER <u>Arthur Brumbaugh</u>		6 NAME OF MOTHER <u>Agnes Lynch</u>	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-16-93</u>	
9 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10 KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11 BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 CAUSE OF DEATH PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation due to</u> DUE TO b) <u>2nd degree burns</u> DUE TO c) <u>1st degree burns</u>		14 MOTHER'S MAIDEN NAME <u>Agnes Lynch</u>	
15 OTHER SIGNIFICANT CONDITIONS <u>1st degree burns</u>		16 ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21 I certify that I took charge of the remains described above and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22 DATE SIGNED <u>5/28/1967</u>	
23a BURIAL CREMATION <u>BURIAL</u>		23b DATE THEREOF <u>5-31-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d LOCATION (City or town) (County) (State) <u>Silver Springs Maryland</u>	

GASCH'S 4739 Baltimore Ave. Hyattsville, Md.

MAY 31 1967

John A. Judge



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1-66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06928

06913

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, furnished, or received before death) a. STATE Maryland b. COUNTY Montgomery			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY (If in hospital, give date of admission) 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 10210 Capitol View Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED Type or print John Bradley Lund				4 DATE OF DEATH Month May Day 23 Year 1967			
5 SEX Male		6 COLOR OR RACE Cauc		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH November 29, 1962 9 AGE (in years, months, and days) 4 yrs	
10 USUAL OCCUPATION (If deceased was not employed, give kind of work done last week, or if retired, give last occupation) None		10b. K. NO. OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 COUNTRY OF WHAT COUNTRY? USA	
13 FATHER'S NAME Jeffrey Lund				14 MOTHER'S MAIDEN NAME Melinda Middleton			
15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		15b. (If yes, give war or dates of service) None		16 SOCIAL SECURITY NO. None		17 INFORMANT Jeffrey Lund Address 9400 Adelphi Road, Adelphi, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral lobular pneumonia DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) severe cerebral infarct DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20a. TIME OF INJURY Month Day, Year Hour am pm 19		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY Home, farm, factory, street, office bldg, etc.)		20d. (City or town, County, State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Walden K. Beiden M.D. EXAMINER'S NAME (Type) BEIDEN K. WALTER M.D.				22. DATE SIGNED 5/24/1967			
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE THEREOF May 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		23d. LOCATION (City or Town, County, State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR John B. Thomas, Turner E. Pumphrey, Inc.				25. DATE BY REGISTRAR MAY 26 1967 25b. SPECIAL AGENT John B. Thomas			

434 Georgia Avenue
Silver Spring, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06923

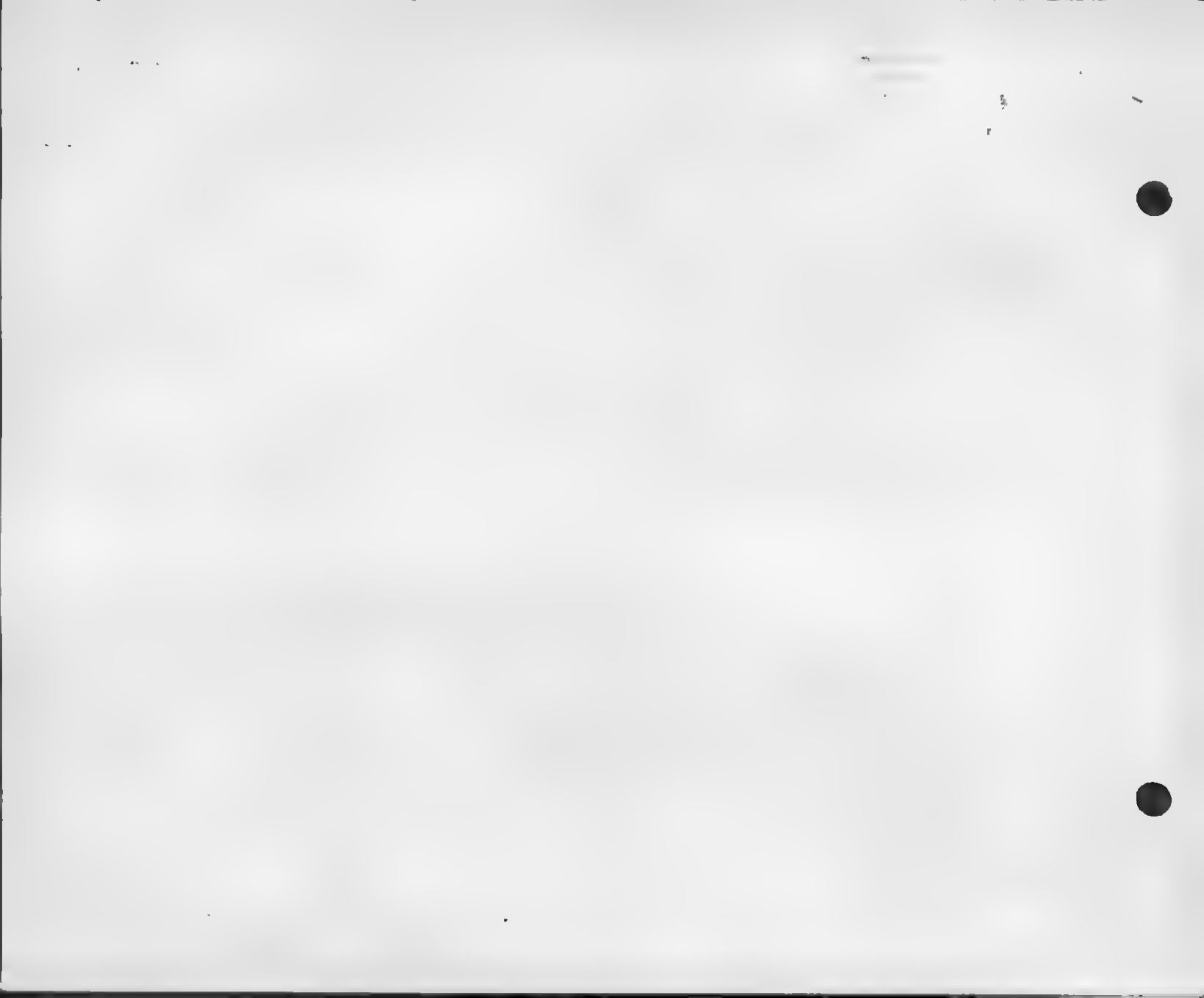
CERTIFICATE OF DEATH

06914

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, 1 institution Residence before admission) a. STATE <u>Virginia</u> b COUNTY <u>Arlington</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN b <u>9 1/2</u> hours	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>		e STREET ADDRESS <u>4201 31st Street, South</u>	
3 NAME OF DECEASED (Type or print) <u>Fay Elizabeth Mahon</u>		4 DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 9, 1934</u>
9 AGE (in years last birthday) <u>32</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Systems Analyst</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	
13 FATHER'S NAME <u>Julius Book</u>		14 MOTHER'S MAIDEN NAME <u>Lee Kornegay</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>434-46-9970</u>	
17 INFORMANT <u>The Medical Record</u>		18 ADDRESS <u>The Clinical Center, Bethesda, Md. 20014</u>	
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Herniation</u> DUE TO (b) <u>Metastatic Tumor</u> DUE TO (c) <u>Malignant Melanoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>7 Mos.</u> <u>2 Yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>May 5</u> , 19 <u>67</u> to <u>May 5</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>May 5</u> , 19 <u>67</u> , and that death occurred at <u>10:40M</u> , from causes and on the date stated above			
22a SIGNATURE <u>Charles L. Vogel</u>		22b DATE SIGNED <u>May 6, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Charles L. Vogel, M. D.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a BURIAL OR CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>Burial-transit 5-7-67</u>		<u>Grace Mem. Park</u>	<u>Plaquemine, Louisiana</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>MAY 9 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse this certificate within the word pending in parentheses. Enter 18 Give Pages 2 a copy to the funeral director. Page 4 to be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

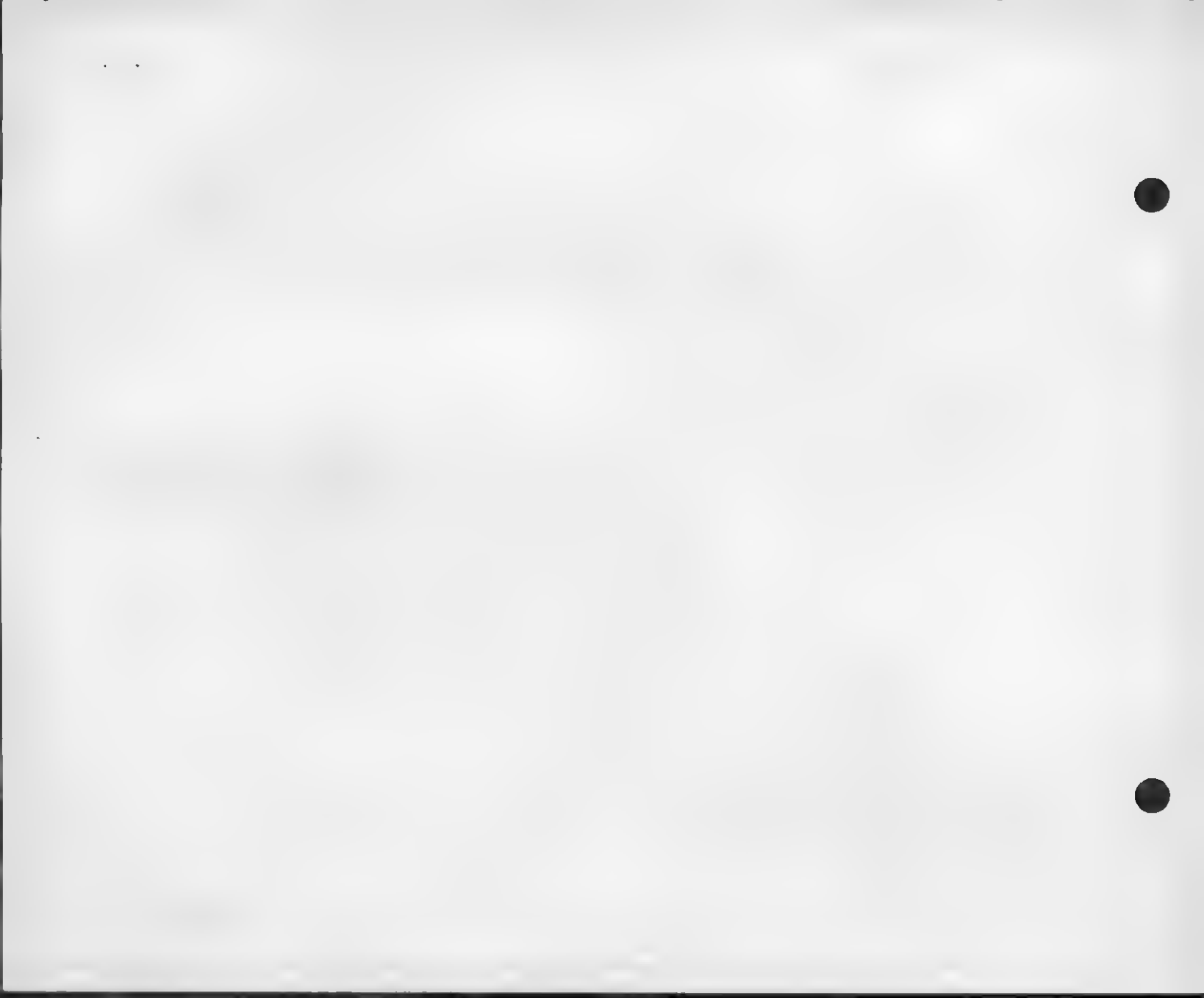
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06930

06915

PLACE OF DEATH CITY <u>MONTGOMERY</u> MARYLAND		USUAL RESIDENCE When first occupied STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>	
LENGTH OF STAY IN MD <u>DOA</u>		CITY OR TOWN (If outside State) <u>SILVER SPRING</u>	
NAME OF DECEASED <u>WASHINGTON SAN & HOSPITAL</u>		STREET ADDRESS <u>4006 Sampson Road</u>	
NAME OF DECEASED First <u>IDA</u> Middle <u>VIOLET</u> Last <u>MANDLEY</u>		DATE OF DEATH <u>5 26 1967</u>	
SEX <u>F</u>	COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	DATE OF BIRTH <u>2-25-1898</u>	
OCCUPATION (Specify if deceased was a housewife) <u>Housewife</u>		BIRTHPLACE (State, city, county) <u>WASH. D.C.</u>	
FATHER'S NAME <u>SAMUEL BLACKMAN</u>		MOTHER'S MAIDEN NAME <u>IDA STEWART</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>577-28-0039</u>	
17 INFORMANT <u>Betty Mandley</u>		Address <u>12304 Ga. Ave.</u>	
18 CAUSE OF DEATH (Enter only one cause per line) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Arteriosclerotic Heart & Blood Vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____			
19 OTHER IMPORTANT CONDITION (Enter condition if death was NOT related to the terminal condition) <u>None</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
21. I certify that I took charge of the remains described above and on the day of death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Belden R. Neap</u>		DATE SIGNED <u>5/26/1967</u>	
EXAMINER'S NAME <u>BELDEN R. NEAP M.D.</u>			
Burial <u>May 29, 1967</u> <u>Cedar Hill Cemetery</u> <u>Suitland, Maryland</u>			
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06931

CERTIFICATE OF DEATH

06916

1 PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TOWN Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Masten		4 DATE OF DEATH Month Day Year May 21 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 5, 1889
9 AGE (In years last birthday) 78 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11 BIRTHPLACE (County & State, or foreign country) Italy		12 CITIZEN OF WHAT COUNTRY? Italy	
13 FATHER'S NAME Nunziato Masten		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 093-30-5088	
17 INFORMANT Nunziato Masten		Address 14010 Travilah Road Rockville, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cerebral Hemorrhage with Right Hemiparesis DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Ischemic Disease		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-20-1967 to 5-21-1967 , that (I) (we) last saw the deceased alive on 5-20-1967 , and that death occurred on 5-21-1967 at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacker, MD.		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacker, MD.		22d. ADDRESS Russell Avenue, Gaithersburg, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 5/24/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Maryland
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

Medical Examiner notified and approved.
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

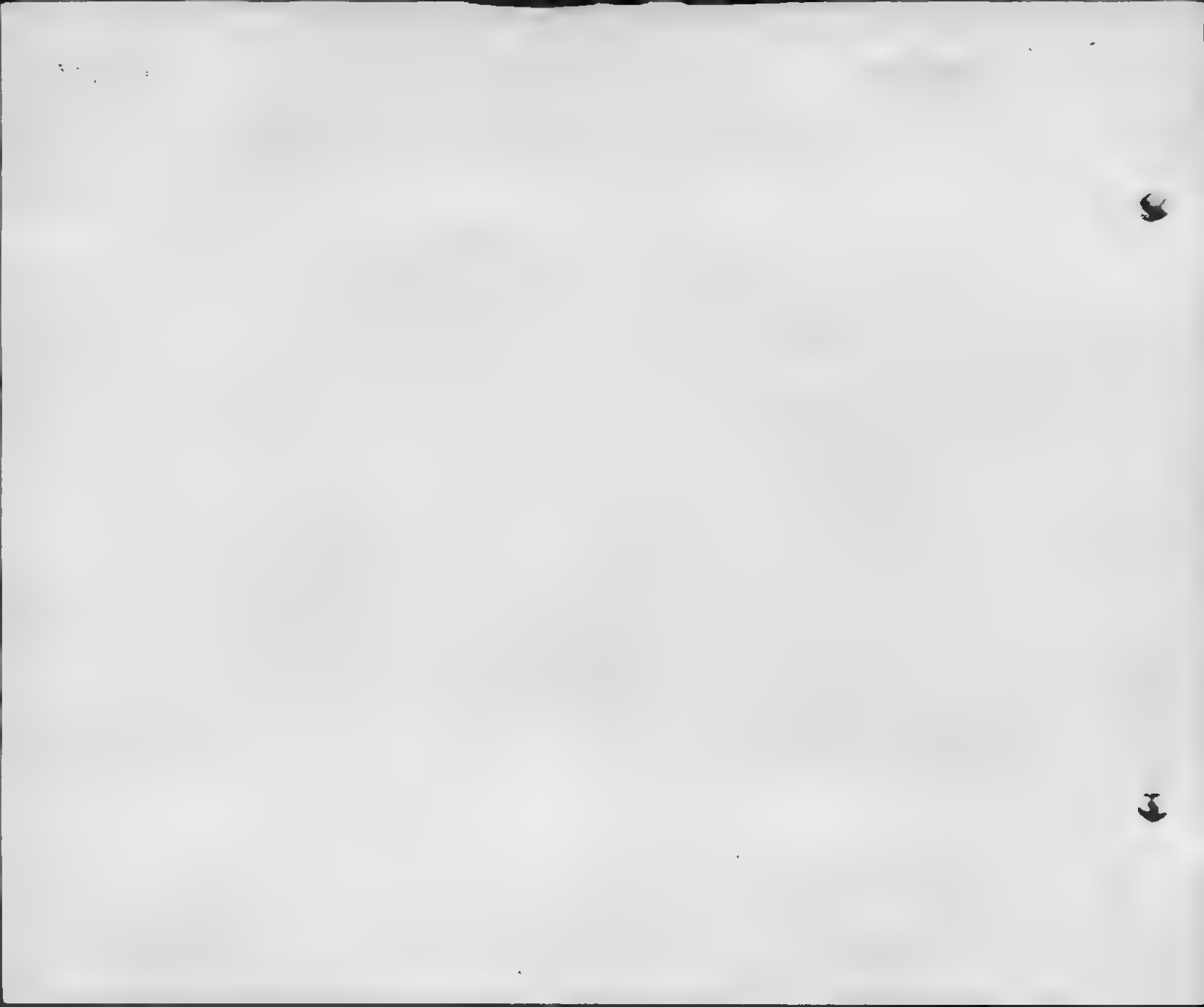
06932

06917

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>86 41</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> d. STREET ADDRESS <u>712 CRASSA</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Paul Masters</u>		4. DATE OF DEATH Month Day Year <u>MAY 12 1967</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/12/67</u> 19. AGE (In years last birthday) yrs. Months Days Hours Min. <u>8 4</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK PAUL MASTERS</u>		14. MOTHER'S M maiden NAME <u>ANNE LOUISE ADAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes, no, or unknown</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>ANNE LOUISE ADAMS - Mother</u> Address <u>8615</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - Atelectasis of lung</u> DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>8 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Rockville, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12, 1967</u> to <u>5/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/12, 1967</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Richard M. Auld</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard M. Auld</u>		22b. DATE SIGNED 22d. ADDRESS <u>809 Views Mill Rd, Rockville, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/17/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAY 18 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

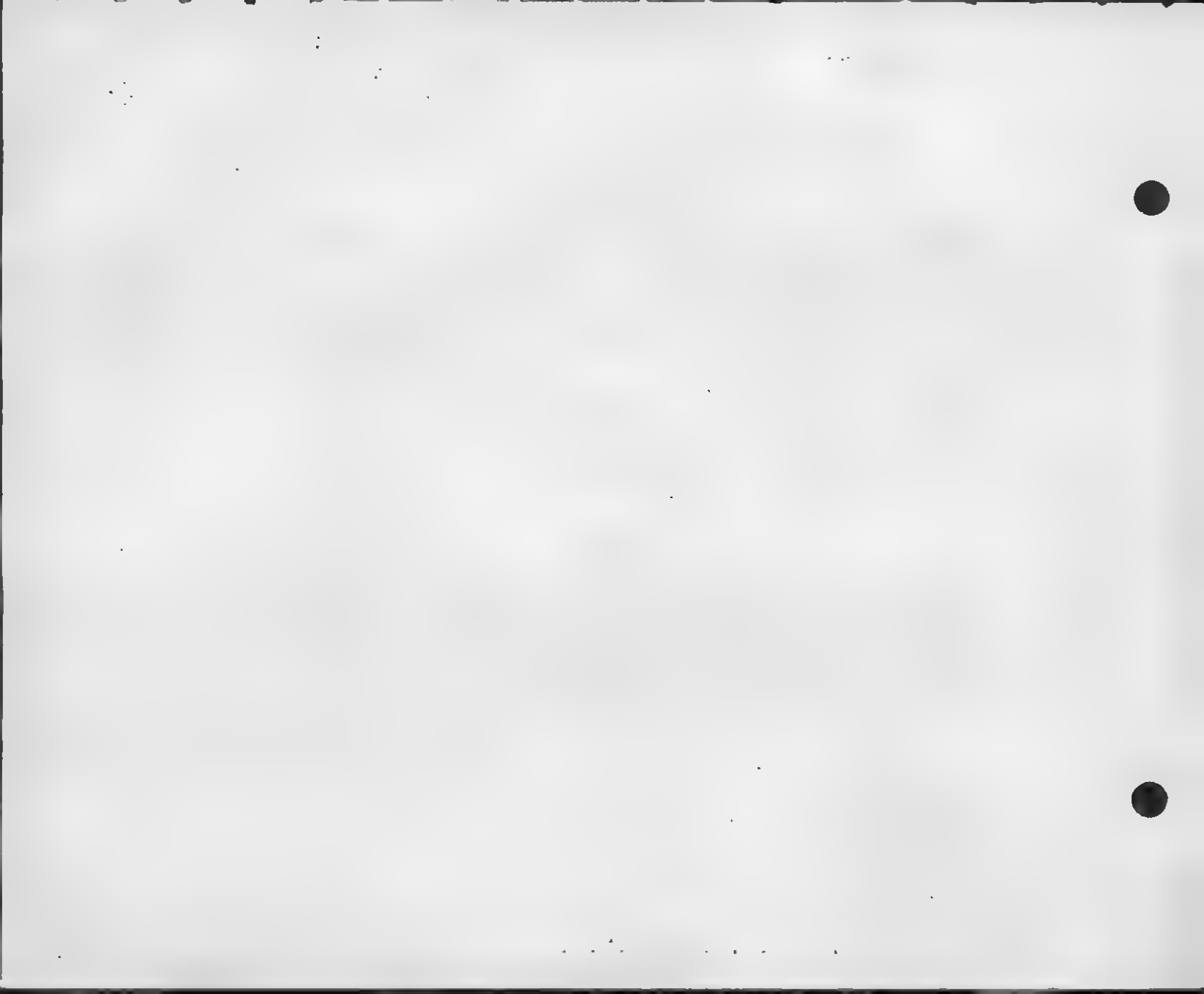


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06933 CERTIFICATE OF DEATH 08422

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DC 20016 c. LENGTH OF STAY IN 1b 9-3-65 to 5-30-67 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Westwood-5101 Ridgefield Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DC 20016 d. STREET ADDRESS 5509 Tammahagan Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) E. LOISE T. McCONVILLE				4. DATE OF DEATH MAY 30 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1875		9. AGE (In years last birthday) 91 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (County & State, or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL S. KELLER				14. MOTHER'S MAIDEN NAME MARY L. BRAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - -		16. SOCIAL SECURITY NO. 219-57-9708		17. INFORMANT Donald H. McConville Address 6411 10th St, NW, Wash, D.C. 20037			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO Chronic Atherosclerotic Heart Disease (b) Chronic Atherosclerotic Heart Disease DUE TO Chronic Atherosclerotic Heart Disease (c) Chronic Atherosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - -						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 54 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1962 to May 30, 1967 , that (I) last saw the deceased alive on May 28 1967 , and that death occurred at 6:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James J. Foster				22b. DATE SIGNED 5/30/67			
22c. PHYSICIAN'S NAME (Type) JAMES J. FOSTER				22d. ADDRESS 1746 K ST NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc.				25a. REC'D BY REGISTRAR 1		25b. REGISTRAR'S SIGNATURE 1	
5130 Wisc. Ave. N.W. Wash. D.C.				DATE 5/30/67			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER

5 may be retained for your files

TO FUNERAL DIRECTOR

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1-67

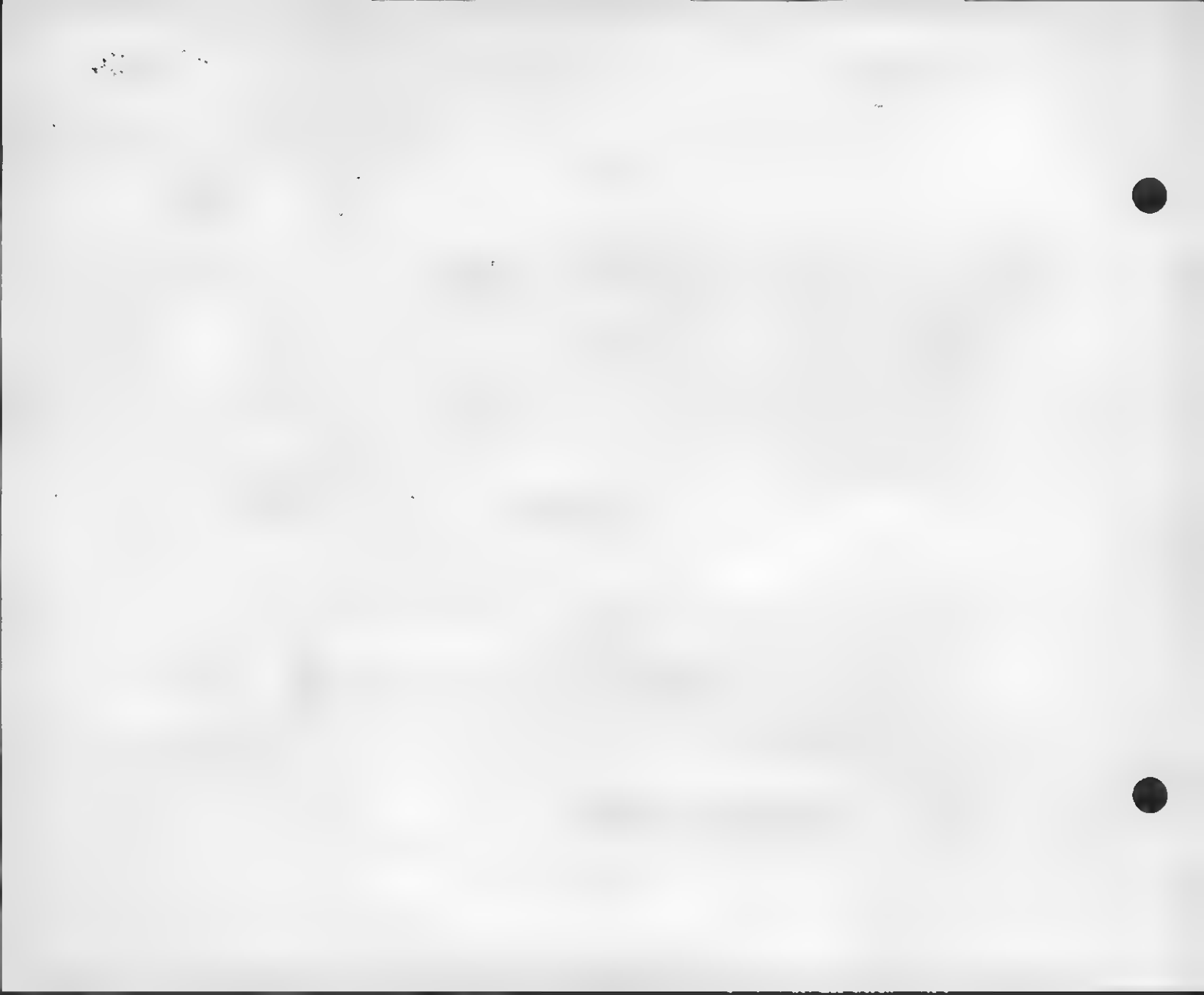
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06534

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08423

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN <u>Potomac River</u> c RURAL <input type="checkbox"/> <u>DoA</u>		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u> c CITY OR TOWN <u>Bowie</u>	
3 NAME OF HOSPITAL OR INSTITUTION (f of n hospital give street address) <u>U.S. Park Great Falls</u>		d STREET ADDRESS <u>Tompkins Lane</u>	
5 NAME OF DECEASED (Type print) SEX <u>Fe</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH <u>May 23, 1949</u>		4 DATE OF DEATH <u>May 28</u> 19 <u>67</u>	
9a PATIENT (Give kind of work done or kind of business or industry) <u>school</u>		11 BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13 FATHER'S NAME <u>William J McCoy</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Child & Parents</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line f. (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE f. <u>Asphyxia due to Drowning</u> DUE TO (b) <u>SMIT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Due to</u> DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH <u>SMIT</u>	
19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20 DECEASED HOW INJURED (Enter only one cause per line f. (b) and (c)) <u>Fell in river when wading and slipped on rock</u>		21 DECEASED HOW INJURED (Enter only one cause per line f. (b) and (c)) <u>Great Falls Montgomery Md</u>	
22 DATE SIGNED <u>6/3/67</u>		23 DATE SIGNED <u>6/3/67</u>	
24 FUNERAL DIRECTOR <u>William J. Ball</u>		25 ADDRESS <u>Baltimore Md</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CC935

CERTIFICATE OF DEATH

06918

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Montgomery		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c LENGTH OF STAY N 1b 3 1/2 years		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9506 Old Georgetown Road			d STREET ADDRESS 9506 Old Georgetown Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First GERTRUDE Middle E. Last McDONALD			4 DATE OF DEATH Month May Day 12 Year 19 67		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 7, 1886		9 AGE (In year, last birthday) yrs 80
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Iowa	
12 CITIZEN OF WHAT COUNTRY? U. S.					
13 FATHER'S NAME Michael Manion			14 MOTHER'S MAIDEN NAME Bridgette Coyne		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 517 03 2696		17 INFORMANT Daughter Address Same as Item 2. Loyola Whittinghill	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO CEREBRAL THROMBOSIS DUE TO CEREBRAL ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 10 YEARS - 11 YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS; SUBCLAVIAN ANEURYSM					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town, county, state)					
21 I certify that (I) (the hospital) attended the deceased from Sept. 1, 1964 to May 12, 1967 that (I) (we) last saw the deceased alive on May 11, 1967 and that death occurred at 8 A. M. from causes and on the date stated above.					
22a SIGNATURE Joseph D. Connor M.D.			22b DATE SIGNED 3-12-67		
22c PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR			22d ADDRESS 9420 Old Georgetown Rd. Bethesda, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 5/13/67		23c NAME OF CEMETERY OR CREMATORY Pleasant Hill	
23d LOCATION (City or Town, county, state) Dunlap, Iowa		25a REC'D BY REGISTRAR MAY 15 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

26936

CERTIFICATE OF DEATH

06919

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>901 - Arula Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>M.</u> Last <u>McMAHON</u>		4 DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/18C</u>
9 AGE (In years last birthday) <u>86</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Teacher</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Wise</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Cornelius Donahue</u>		14 MOTHER'S MAIDEN NAME <u>Kettwick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>Engine 7 Mc Mahon</u>	
17 INFORMANT <u>Engine 7 Mc Mahon</u>		Address <u>Greenwood St. Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation & acute failure</u> DUE TO (b) <u>AS COVD</u> POSSIBLE MYOCARDIAL INFARCTION DUE TO (c) <u>Eldage</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis</u>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>pm</u> 19 <u>67</u>		20d. INJURY OCCURRED Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 1</u> , 19 <u>67</u> , to <u>May 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> , 19 <u>67</u> , and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. C. Bufalino</u>		22b. DATE SIGNED <u>May 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. C. Bufalino, M.D.</u>		22d. ADDRESS <u>1429 University Blvd. - Silver Spring</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/11/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. CLEMENS CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>WILMINGTON, DE.</u>
24. FUNERAL DIRECTOR <u>James P. D'Amico, 2222 W. 10th St. - Silver Spring</u>		25a. REC'D BY REGISTRAR <u>May 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

26937

CERTIFICATE OF DEATH

06920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>LSA</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>7705 New Market St</u>	
3 NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Lewis</u> Last <u>McNey</u>		4 DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 CO. OR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 6th 1896</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		9b KIND OF BUSINESS OR INDUSTRY <u>Simon Lodge</u>	9c AGE (in years last birthday) <u>70</u> yrs
10a BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Edward E. McNey</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Schneider</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16 SOCIAL SECURITY NO <u>577-03-6299</u>	
17 INFORMANT <u>Mrs McNey - Above</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>coronary occlusion</u> DUE TO (c) <u>coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WA AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>11-3</u> 19 <u>66</u> to <u>5-25</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-15</u> 19 <u>67</u> , and that death occurred at <u>6:00</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>A. J. Brennan</u>		22b DATE SIGNED <u>May 26, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>		22d ADDRESS <u>Cherry Chase, MD</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-29-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Leesburg Cemetery</u>	23d LOCATION (City or Town, County, State) <u>Leesburg, Virginia</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR DATE <u>JUN 1 1967</u>	



26935

CERTIFICATE OF DEATH

06921

1 PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admss on) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <u>St. Elizabeth's</u>		d. STREET ADDRESS <u>5615-31st Highway</u>	
3 NAME OF DECEASED (Type or print) <u>Hilda Mae Messenger</u>		4 DATE OF DEATH <u>May 5 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>81</u> <u>17</u> <u>94</u> <u>74</u> <u>74</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Nebraska</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Carl August Leinen</u>		14 MOTHER'S M A DEN NAME <u>Tolson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>216</u>	
17 INFORMANT <u>William P. S. ...</u>		Address	
18 CAUSE OF DEATH (Enter on y one cause per ne for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Arteriosclerotic CVD</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic CVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>1962</u> , 19 <u>1967</u> to <u>THE PRESENT</u> that (I) (we) last saw the deceased alive on <u>MAY 4</u> , 19 <u>67</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Edward W. Youngblood</u>		22b DATE SIGNED <u>5-5-67</u>	
22c PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>		22d ADDRESS <u>WASHINGTON CLINIC, WASHDC</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>5-9-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REG. BY REGISTRAR <u>MAY 9 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06933

06922

PLACE OF DEATH
a COUNTY

Montgomery

MARY AND

2 USUAL RESIDENCE (Where deceased lived before death)
a STATE

Md.

b COUNTY

Montgomery

c CITY OR TOWN (If rural, write RURAL and give nearest town)

Bethesda

LENGTH OF STAY IN b

1 yr.

c CITY OR TOWN (If rural, write RURAL)

Bethesda

d NAME OF HOUSEHOLD OR INSTITUTION (If not in hospital, give street address)

5480 Wisconsin Ave APT-610

d STREET ADDRESS

5480 Wisconsin Ave

3 NAME OF DECEASED (Type or print)

First Eva

Middle D

Last Michaelson

4 DATE OF DEATH

May 7

1967

5 SEX

Female

6 COLOR OR RACE

White

7 MARRIED

NEVER MARRIED

8 DATE OF BIRTH

March 4, 1898

9 AGE

79

10 USUAL OCCUPATION (If not at work, give kind of work done during most of working life even if retired)

Housewife

10b KIND OF BUSINESS OR INDUSTRY

at home

11 BIRTHPLACE (State or foreign country)

Maryland

12 OF WHAT COUNTRY

U.S.A

13 FATHER'S NAME

Louis Levy

14 MOTHER'S MAIDEN NAME

Rebecca Friedman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16 SOCIAL SECURITY NO

574-22-9204-A

7 INFORMANT

Rosalie - Koonin

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Coronary Insufficiency Acute

Conditions (any which gave rise to immediate cause (a), stating the underlying cause lost)

DUE TO

Cardio Vascular Disease

(c)

INTERVAL BETWEEN DEATH

32

Years

19 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE "AND" OR GIVEN IN PART

20 EXTERNAL CAUSES

PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, place, time, etc.)

22 TIME OF DEATH (If known, give day, month, year, hour, minute)

9

23 INJURY OCCURRED

Work ☐ Not Work ☐

24 PLACE OF INJURY (Home, etc.)

21 I certify that I took charge of the remains described above held an Autopsy ☐

death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐

ACTUAL SIGNATURE

EXAMINER'S NAME

John G. Ball

JOHN G. BALL

CHIEF MEDICAL EXAMINER

22 DATE SIGNED

5/7/67

23a REMEMORANCE

Burial

23b DATE THEREOF

5-10-67

23c NAME OF CEMETERY OR CREMATORY

D.C. Lodge Cemetery

23d LOCATION (City or Town)

Washington

(County)

D.C.

(State)

D.C.

Holberg Funeral Home 4217-9th St. N.W.

MAY 10 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the health department, writing the ward pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06940

CERTIFICATE OF DEATH

06923

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1716 Alberti Drive</i>		d. STREET ADDRESS <i>1716 Alberti Drive</i>	
3 NAME OF DECEASED (Type or print) <i>Frank Minno</i>		4 DATE OF DEATH Month <i>May</i> Day <i>4</i> Year <i>1967</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Mar 10, 1880</i>
9 AGE (In years last birthday) <i>87</i>		10 IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired steel worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>	
11 BIRTHPLACE (County & State or foreign country) <i>Czechoslovakia</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Unknown</i>		14 MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17 INFORMANT <i>Margaret M. Mendith</i>		Address <i>1716 Alberti Drive Silver Spring, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DISEASE CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>Arteriosclerotic Heart Disease</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <i>Drunk</i> STATING THE UNDERLYING CAUSE (c) <i>Drunk</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Ulcerating Fracture of Femoral Head</i>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5/14/67</i> to <i>5/17/67</i> , that (I) (we) last saw the deceased alive on <i>5/14/67</i> , and that death occurred at <i>8:22</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>John G. Curry</i>		22b. DATE SIGNED <i>5/17/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>John G. Curry</i>		22d. ADDRESS <i>10620 Georgia Ave., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit-Burial</i>	23b. DATE THEREOF <i>May 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Trinity Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>East Taylor Township, Penna.</i>
24. FUNERAL DIRECTOR <i>John E. Murphy, Inc. Silver Spring, Md.</i>		25a. REC'D BY REG. STRAR <i>MAY 8 1967</i>	25b. REG. STRAR'S SIGNATURE <i>Charles Judge</i>



CERTIFICATE OF DEATH

06941

06924

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German Town</u> d STREET ADDRESS <u>3 x 181 RT #1 Silver Spring</u> e RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>Leonard Edward M. Tassiti</u> First Middle Last				4 DATE OF DEATH <u>5/27/67</u> Month Day Year 19 <u>67</u>					
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5/24/67</u>		9 AGE (In years last birthday) yrs F UNDER 1 YEAR Months Days <u>2</u> <u>16</u> HOURS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leonard E. Mitas</u>						14 MOTHER'S MAIDEN NAME <u>Phyllis Jones</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17 INFORMANT <u>Mother</u> Address			
18 CAUSE OF DEATH (Enter on y one cause per one for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congenital Heart Disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 1/2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 24, 1967</u>, to <u>MAY 27, 1967</u>, that (I) (we) last saw the deceased alive on <u>MAY 27, 1967</u>, and that death occurred at <u>M</u>, from causes and on the date stated above.									
22a. SIGNATURE <u>Edward J. Feroli</u> M.D.						22b. DATE SIGNED <u>5/27/67</u>		22c. PHYSICIAN'S NAME (Type)	
22d ADDRESS						22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f	
23a BURIAL, CREMATION REMOVAL (Specify)				23b DATE THEREOF <u>5/29/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		23d LOCATION (City or Town) (County) (State) <u>Chesapeake</u>	
24 FUNERAL DIRECTOR <u>4444</u> <u>316 E. Diamond Ave.</u> <u>BALTIMORE, MD.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>M. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06325

06942

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Pittsburgh</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's Hospital</u>				d. STREET ADDRESS <u>4634 Center Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>East</u> First <u>Mitchell</u> Middle <u>Pittsburgh</u> Last <u>Pittsburgh</u>				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1881</u>	9. AGE (in years last birthday) <u>85</u> yrs	10. FUNDING MONTHS <u>1</u> YEAR <u>1</u> DAYS <u>1</u>	11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>			11. BIRTHPLACE (County & State or foreign country) <u>Greene Co</u>	
13. FATHER'S NAME <u>Peter Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Dasicki Christofilon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>182-28-4439</u>		17. INFORMANT Address <u>Peter Harris, Silver Spring, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis</u> DUE TO (b) <u>Complications of prostate</u> DUE TO (c) <u>E. Coli, from Benz</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>61</u> , to <u>5/3/67</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>5/12/</u> 19 <u>67</u> , and that death occurred at <u>9:50 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>George J. Schenck</u> M.D.				22b. DATE SIGNED <u>5/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>George J. Schenck</u>	
22d. ADDRESS <u>1400 Spruce St</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Homewood Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Pittsburgh, Penna.</u>				
24. FUNERAL DIRECTOR <u>E. P. Murphy, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove garbage papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

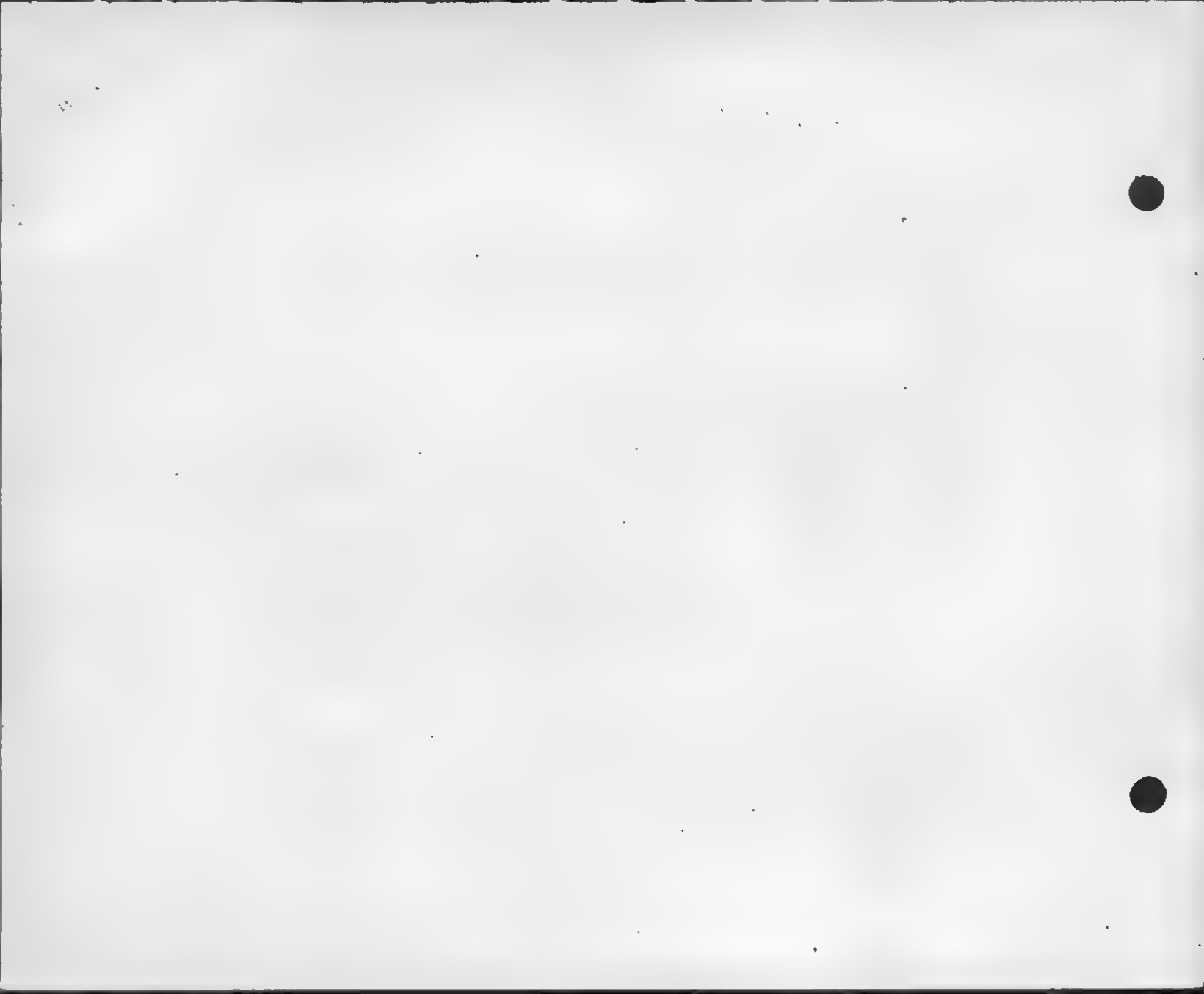


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u> d. STREET ADDRESS <u>3200 Rhode Island Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Eleanor</u>			First <u>Hookey</u>		Middle <u>Moore</u>		Last <u>Moore</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1967</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-20-01</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas R. Nailley</u>					14. MOTHER'S MAIDEN NAME <u>Nathryn Murray</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>565-12-8942-A</u>		17. INFORMANT <u>Mrs. C. J. ...</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular (stroke)</u> DUE TO <u>Cerebrovascular (stroke)</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Cerebrovascular (stroke)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1967</u> to <u>May 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 2, 1967</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Boris RABKIN</u>					22b. DATE SIGNED <u>May 5, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>		
24. FUNERAL DIRECTOR <u>Horne Inc.</u>			25a. REC'D BY REGISTRAR <u>...</u>		25b. REGISTRAR'S SIGNATURE <u>...</u>				

MAY 10 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.


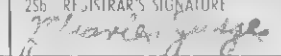
VR A15 (4)
25M 1/67

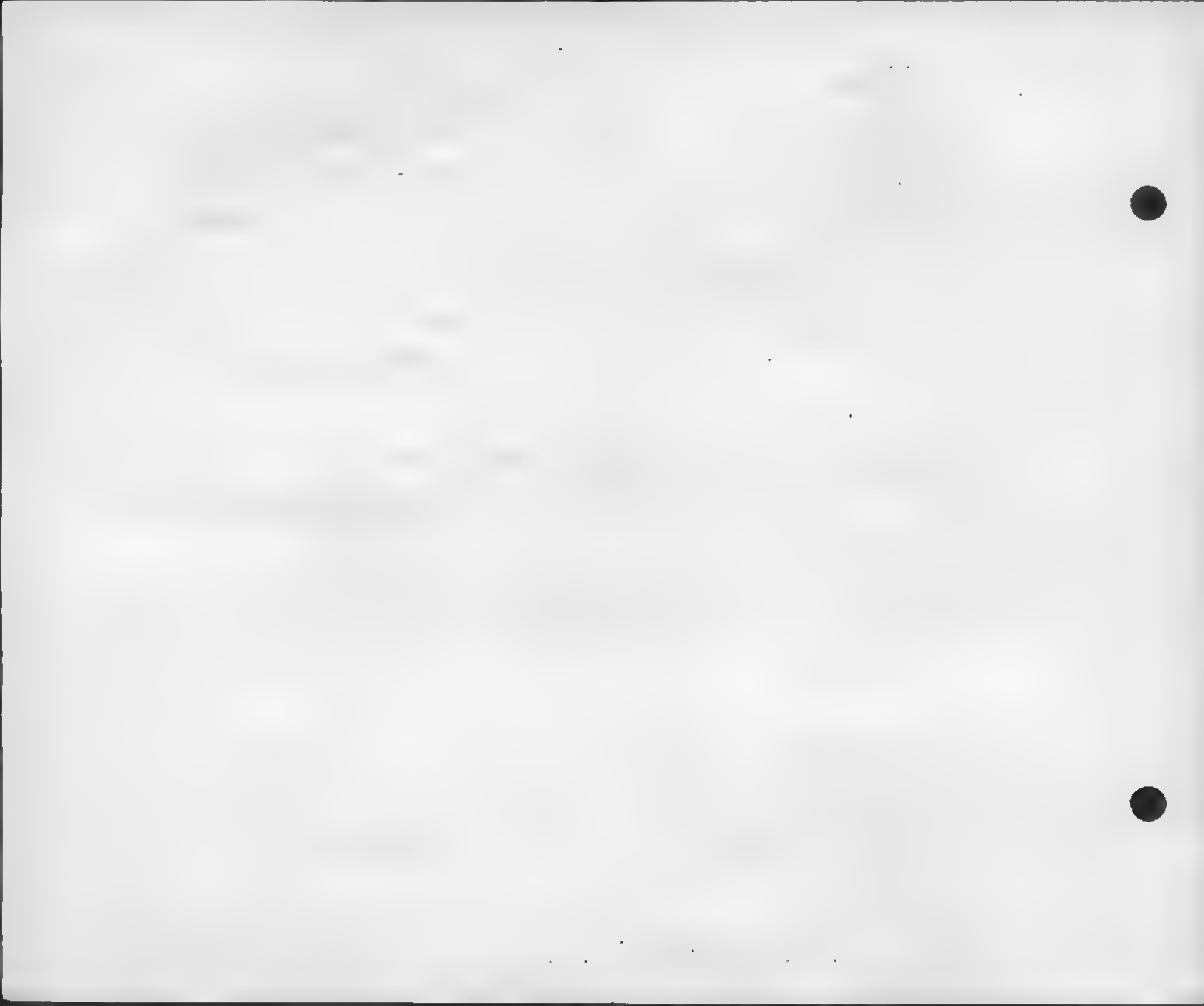
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #1 & 12 Film

36944

CERTIFICATE OF DEATH

06927

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN b 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE NORTH CAROLINA b. COUNTY NEWBORN New Bern c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) NEWBORN New Bern d. STREET ADDRESS RT # 3, BOX 58-E NEWBERNE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GWENDOLYN PHYLECI MOORE		4. DATE OF DEATH Month Day Year MAY 11 19 67	
5. SEX FE	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 AUG 51
9. AGE (In years last birthday) 15 yrs		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
11. BIRTHPLACE (County & State or foreign) New Bern, North Carolina		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL L. MOORE		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left occipital parietal brain abscess, etiology DUE TO undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 3 , 19 67 to May 11 , 19 67 that (I) (we) last saw the deceased alive on May 11 , 19 67 , and that death occurred at 1210PM , from causes and on the date stated above.			
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) D. R. Foreman		22b. DATE SIGNED 12 May 1967	
23a. B. RIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City or town) (County) (State) New Bern North Carolina	
24. FUNERAL DIRECTOR John T. Rhines & Co. 3015 12th St., N.E. Washington, D. C.		25a. REC'D BY REGISTRAR MAY 17 1967	
25b. REGISTRAR'S SIGNATURE 			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06945

06928

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md</u> c LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sanford Hill Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> d STREET ADDRESS <u>1 A Woodland Way</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Eda Morris</u> First Middle Last 5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>June 8</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (In years last birthday) <u>81</u> yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4 DATE OF DEATH <u>5-5-1967</u> Month Day Year 11 BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>James Rowe</u>		14 MOTHER'S M A DEN NAME <u>Isabell White</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO 17 INFORMANT Address <u>Mrs William Moore Greenbelt, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia renal failure</u> DUE TO (b) <u>Chronic glomerulosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>2 yrs.</u> 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)		21 I certify that (1) (this hospital) attended the deceased from <u>Jan.</u> 19 <u>62</u> , to <u>May 4</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>May 4</u> , 19 <u>67</u> , and that death occurred at <u>2:40 AM</u> , from causes and on the date stated above. 22a SIGNATURE <u>James R Coleman MD</u> M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED <u>May 5, 1967</u> 22c PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u> 22d ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY <u>Rocky Springs</u>	
24 FUNERAL DIRECTOR <u>Bear Funeral Home</u> ADDRESS <u>Churchville, Virginia</u>		23d LOCATION (City or Town) (County) (State) <u>Deerfield Virginia</u> 25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <u>MAY 8 1967</u> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

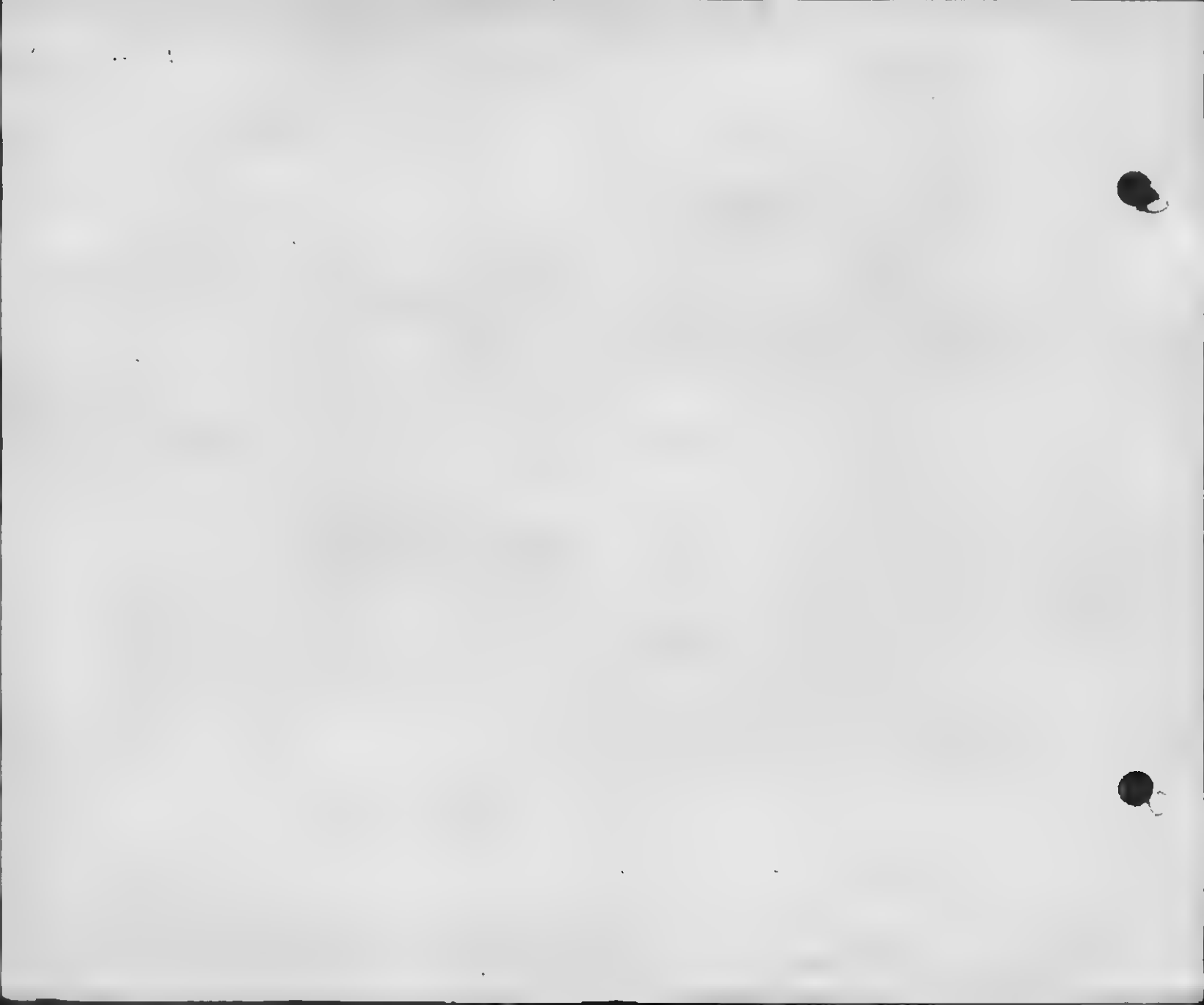
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

26946

CERTIFICATE OF DEATH

06929

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) <u>Randolph Hills Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits write R) <u>Wheaton</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u>		d. STREET ADDRESS <u>2330 Glenmont Circle</u>	
5. SEX <u>Female</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF DEATH <u>May 2, 1967</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>7</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. FATHER'S NAME <u>Quill Grist</u>		14. MOTHER'S MAIDEN NAME <u>Hadie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>578-07-8636</u>	
17. INFORMANT <u>Joseph S. Moser</u>		Address <u>14113 Chelam Ford Road Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO THE TERMINAL ILLNESS OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>Chronic obstructive pulmonary disease</u> <u>Coronary artery disease</u> <u>Myocardial infarction</u>		19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>May 2, 1967</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>M</u> , from the causes and on the date stated above		22a. SIGNATURE <u>Merton L. White, M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Merton L. White, M.D.</u>		22b. DATE SIGNED <u>26 May 1967</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION - City, town or county <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumprey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1967</u>	
25b. REGISTRAR SIGNATURE <u>Warner E. Pumprey, Inc.</u>		25c. REGISTRAR SIGNATURE <u>Warner E. Pumprey, Inc.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

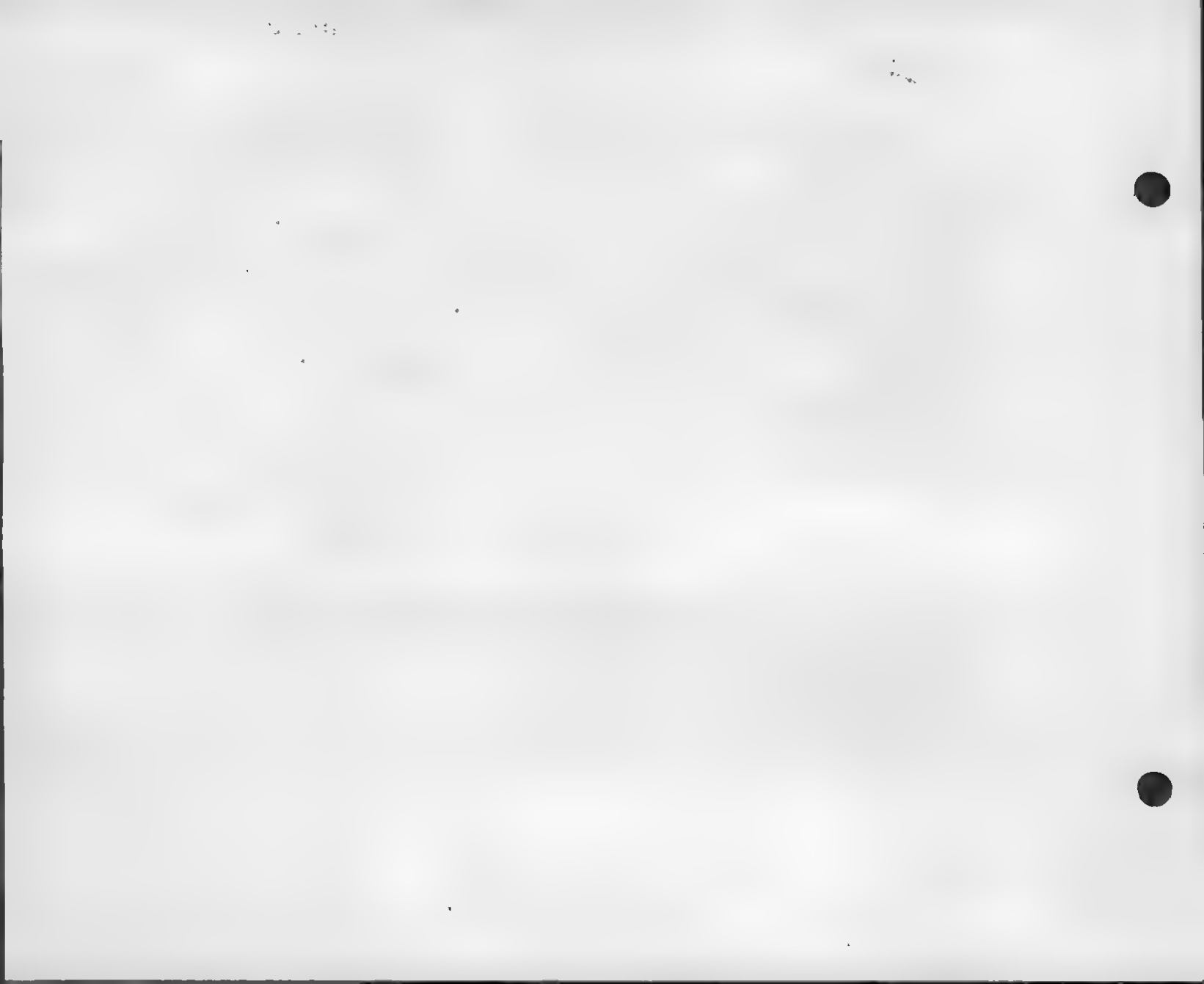
00347

CERTIFICATE OF DEATH

06930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst. or Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Oney		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		d. STREET ADDRESS 9601 Main St.	
3 NAME OF DECEASED (Type or print) First Middle Last Winifred E. Mullinix		4 DATE OF DEATH Month Day Year May 5 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 3, 1893
9 AGE (In years or birthday) yrs 74		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11 BIRTHPLACE (County & State or foreign country) Damascus, Md.
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Levi Pearce	
14 MOTHER'S MAIDEN NAME Marian Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 212-10-3964B		17. INFORMANT Address Herman W. Mullinix, Item 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart attack DUE TO arteriosclerosis (b) Diabetes is considered a contributing cause DUE TO loss of (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1933 , 19 to 1967 , that (I) (We) last saw the deceased alive on 19-7 , and that death occurred at 10 M, from causes and on the date stated above			
22a. SIGNATURE M. McKendree Boyer, M.D.		22b. DATE SIGNED May 5, 1967	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22d. ADDRESS 9701 Church Street, Damascus, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF May 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	23d. LOCATION (City or Town) (County) (State) Damascus, Md.
24 FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE MAY 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06943

06931

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first tuition. Residence before admission) a. STATE Washington, D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 2 1 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Gertrude Emma Magio		4 DATE OF DEATH 10/31/67 Month Day Year	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/29/1894
9 AGE in years 73 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11 BIRTHPLACE (County & State or foreign country) Tachau, Germany
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Joseph Hiller	
14 MOTHER'S MAIDEN NAME Mary		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 079-60-1335		17 INFORMANT Mr. Elmer Magio-1707 Columbia Rd.,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Generalized Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 years 4 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>Urinary Infection</u> <u>Decubiti</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1966</u> , to <u>May 31, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>May 30, 1967</u> , and that death occurred at <u>12:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. Dyer M.D.</u>		22b. DATE SIGNED 5-31-67	
22c. PHYSICIAN'S NAME (Type) Robert E. Dyer M.D.		22d. ADDRESS 915 19th St NW	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/2/67	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR <u>Chambers, George Edward, Sr.</u>		25a. REC'D BY REGISTRAR DATE JUN 5 1967	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06949

CERTIFICATE OF DEATH

06932

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN TB <u>98 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d STREET ADDRESS <u>Box 3</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Harry Lee Naylor, Sr.</u>		4 DATE OF DEATH Month Day Year <u>May 18 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>16 December 1911</u>
9 AGE (In years last birthday) <u>55 yrs</u>		10 IF UNDER 1 YEAR Months Days Hours Min <u>19 19 47</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Reuben Naylor</u>		14 MOTHER'S MAIDEN NAME <u>Maude Cline</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ice) <u>No</u>		16 SOCIAL SECURITY NO <u>188-09-5241</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage left carotid artery</u> DUE TO (b) <u>Recurrent carcinoma hypopharynx</u> DUE TO (c) <u></u> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 months</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 9, 19 67</u> , to <u>May 18</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 18</u> , 19 <u>67</u> , and that death occurred at <u>6:10 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>James J. Ryan</u> M.D.		22b DATE SIGNED <u>19 May 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>James J. Ryan, M.D.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>5/21/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d LOCATION (City or Town) (County) (State) <u>Sabillasville, Frederick Md.</u>
24 FUNERAL DIRECTOR <u>William H. Hark</u>		25a ADDRESS <u>Waynesboro, Penna.</u>	
25b DATE <u>MAY 22 1967</u>		25c REGISTRAR'S SIGNATURE <u>J. H. Hark</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or burn papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12. 4. 75



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06950

06933

1 PLACE OF DEATH a. COUNTY <u>Longmery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Longmery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c LENGTH OF STAY IN 1b <u>B.O.A.</u>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Consington</u>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d STREET ADDRESS <u>3012 Jennings Road</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CHESTER AL ROSE NEECE</u>				4 DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/17/13</u>	9 AGE (in years lost birthday) <u>53</u> yrs	F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		F UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Construction</u>			10b KIND OF BUSINESS OR INDUSTRY <u>SAINT PAUL, VA.</u>		11 BIRTHPLACE (County & State or foreign country) <u>SAINT PAUL, VA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>Edward Charles Neece</u>				14 MOTHER'S MAIDEN NAME <u>Delphia Mullins</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>233-14-0635</u>		17 INFORMANT <u>James Neece</u> Address <u>3012 Jennings Road</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4301</u> <u>acute arrhythmia</u> DUE TO <u>heart block after fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>coronary insufficiency</u> DUE TO (c) <u>100 days</u> <u>2 yrs.</u>							INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <u>100 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-4-1967</u> to <u>May 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-28-1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above							
22a SIGNATURE <u>NC. SHOEMAKER</u>				MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATESIGNED <u>5-6-67</u>	
22c PHYSICIAN'S NAME (Type) <u>NC. SHOEMAKER</u>				22d ADDRESS <u>811 Dale Drive Silver Spring Md</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>May 10, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parlawn Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>			
24 FUNERAL DIRECTOR <u>John J. Thomas 8434 Georgia Avenue</u>				25a RECD BY REGISTRAR DATE <u>MAY 11 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

Received with medical certificate

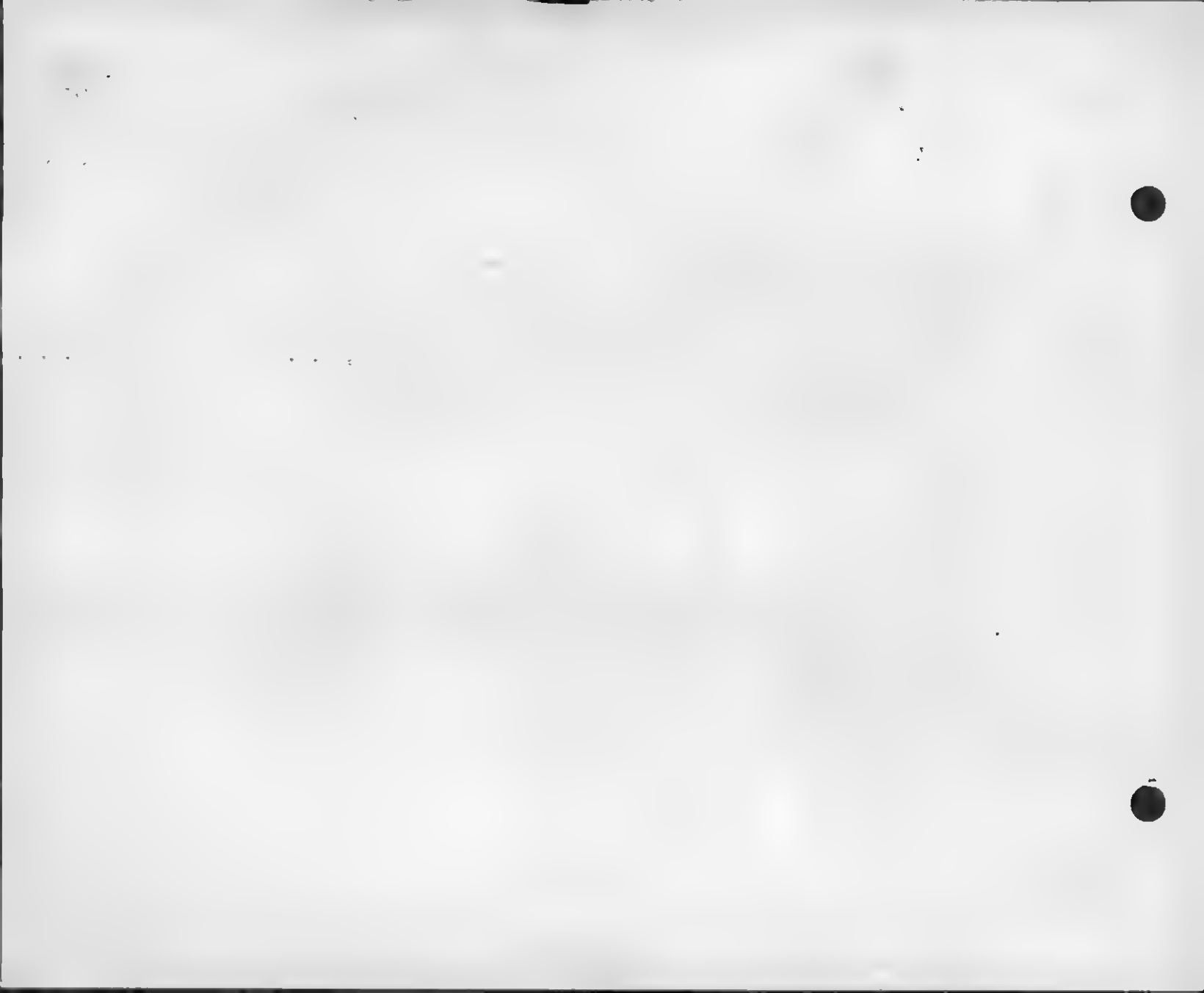
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06934

CLEARED BY DR. REAP



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06952

CERTIFICATE OF DEATH

06935

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) <input checked="" type="checkbox"/> a STATE <u>MARYLAND</u> b COUNTY <u>PRINCE GEORGES</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WATERGATE PARK</u>		c LENGTH OF STAY IN 1b <u>5 YRS.</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sun & Hospital</u>		d STREET ADDRESS <u>5 Twin Oak Dr</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>(none)</u> Last <u>Meri</u>		4 DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-18-1896</u>
9 AGE (in years lost birthday) <u>76</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Shoemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Antonio Meri</u>		14 MOTHER'S MAIDEN NAME <u>Mary Caminati</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>217-32-1665</u>	
17 INFORMANT <u>GIOVANNA MERI</u>		Address <u>2a, b, c, d above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			
DUE TO <u>Arteriosclerotic Heart Disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>4 months</u>			
(c) <u>years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>June</u> <u>1964</u> to <u>May 14</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>May 14</u> <u>1967</u> , and that death occurred at <u>3:25 AM</u> , from <u>causes and on the date stated above</u>			
22a SIGNATURE <u>E. P. Ingeel</u>		22b DATE SIGNED <u>May 14, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>E. P. INGEL</u>		22d ADDRESS <u>800 Buchanan St NE Wash DC</u>	
23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE THEREOF <u>17 MAY 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>PARKLAWN</u>	23d LOCATION (City or town) (County) (State) <u>Rockville Md</u>
24 FUNERAL DIRECTOR <u>KINARD FUNERAL HOME</u>		25a REC'D BY REGISTRAR <u>5400 GA. AVE NW WASH, DC</u>	
		25b REGISTRAR'S SIGNATURE <u>Richard Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06953

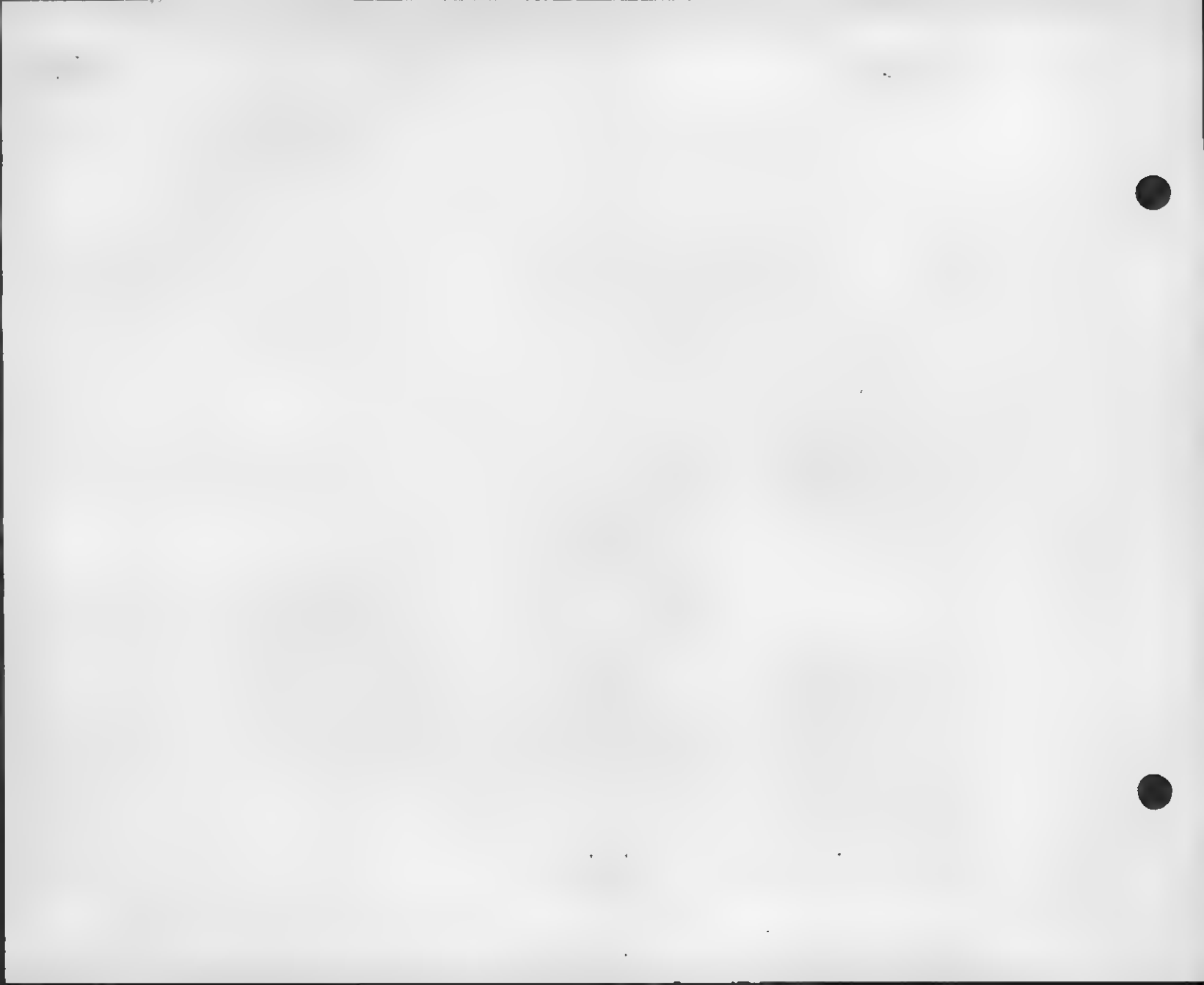
CERTIFICATE OF DEATH

05936

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 4802 Barrymore Drive	
3 NAME OF DECEASED (Type or print) John Anthony O'PRAY		4 DATE OF DEATH Month May Day 14 Year 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 27, 1901
9 AGE (In years last birthday) 65 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy, Civil Service		12 BIRTHPLACE (County & State or foreign country) New York City, N.Y.	
13 FATHER'S NAME John O'Pray		14 MOTHER'S MAIDEN NAME Mary Glancey	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes 1941-1961		16 SOCIAL SECURITY NO 082-16-7026	
17 INFORMANT Mrs. Mary H. O'Pray		Address Oxon Hill Maryland 4802 Barrymore Drive	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis DUE TO (c) Severe hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 29, 1967 to May 14, 1967 that (X) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 2:35 PM from causes and on the date stated above.			
22a SIGNATURE <i>[Signature]</i>		22b DATE SIGNED May 16, 1967	
22c PHYSICIAN'S NAME (Type) R. J. KINNEY, M.D.		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5-19-67	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington, Va.	
24 FUNERAL DIRECTOR Robert E. Wilhelm		25a REC'D BY REGISTRAR MAY 18 1967	
Funeral Home, 4308 Suitland Rd., Suitland, Md.		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one event, with a 72-hour after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate writing the ward, pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 167

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06954

06937

PLACE OF DEATH <i>Montgomery</i>				USUAL RESIDENCE <i>Maryland Montgomery</i>			
<i>Silver Spring D.C.A.</i>				<i>Silver Spring</i>			
NAME OF HOSPITAL OR INSTITUTION <i>Holy Cross Hospital</i>				STREET ADDRESS <i>2708 Lindell St.</i>			
NAME OF DECEASED <i>HERMAN MARLOW ORRISON</i>				DATE OF DEATH <i>MAY 29 1967</i>			
SEX <i>Male</i>				DATE OF BIRTH <i>11-23-1912</i>			
COLOR OR RACE <i>Cauc.</i>				MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11-23-1912 <i>56</i>			
OCCUPATION <i>Salesman</i>				BIRTHPLACE <i>West Virginia</i>			
FATHER'S NAME <i>Harry Marlow Orrison</i>				MOTHER, MAIDEN NAME <i>C.D.A. SHAFER</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH CAUSED BY IMMEDIATE CAUSE (a) <i>4/10/1</i> DUE TO Conditions of any which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)				19 INFORMATION <i>Margaret Orrison (wife)</i> SAME			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, Part II, or Part III)			
21 I certify that I took charge of the persons described above held on Autopsy, <input checked="" type="checkbox"/> Inspection, <input checked="" type="checkbox"/> Inquiry, <input checked="" type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>				22 DATE SIGNED <i>5/29/1967</i>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME Type, <i>BELDEN R. REAP, M.D.</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
REMOVAL (Specify) <i>Burial</i>				DATE OF REMOVAL <i>June 1, 1967</i>			
NAME OF CEMETERY <i>Reform Cemetery</i>				LOCATION <i>Middletown, Maryland</i>			
NAME OF FUNERAL HOME <i>Warner E. Humphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>			
DATE <i>JUN 2 1967</i>				TIME <i>11:00</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06955

06938

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>DISTRICT OF COLUMBIA</u> b COUNTY <u>WASHINGTON</u>	
b CITY OR TOWN (If inside corporate limits write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY N 1b <u>DOA.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT E. PHARMES</u>		4 DATE OF DEATH Month Day Year <u>MAY 16 19 67</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>10/11/18</u>
9 AGE (In years last birthday) <u>48</u> YRS		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M.	
11 BIRTHPLACE (State or foreign country) <u>Washington, D.C., U.S.A.</u>		12 PART OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Pharmes</u>		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>578-12-3715</u>	
17 INFORMANT <u>Mrs. Ruth Drickson</u> Address <u>Grandview</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute, right coronary art.</u> INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min.</u>			
(b) <u>Coronary arteriosclerosis</u> years			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>5/17/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL (CREMATION) REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	23d LOCATION (City or town) (County) (State) <u>Maryland</u>
24 FUNERAL DIRECTOR <u>Stewart Funeral Home-4001 Benning Rd.,</u>		25a REC'D BY REGISTRAR <u>MMAY 19 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

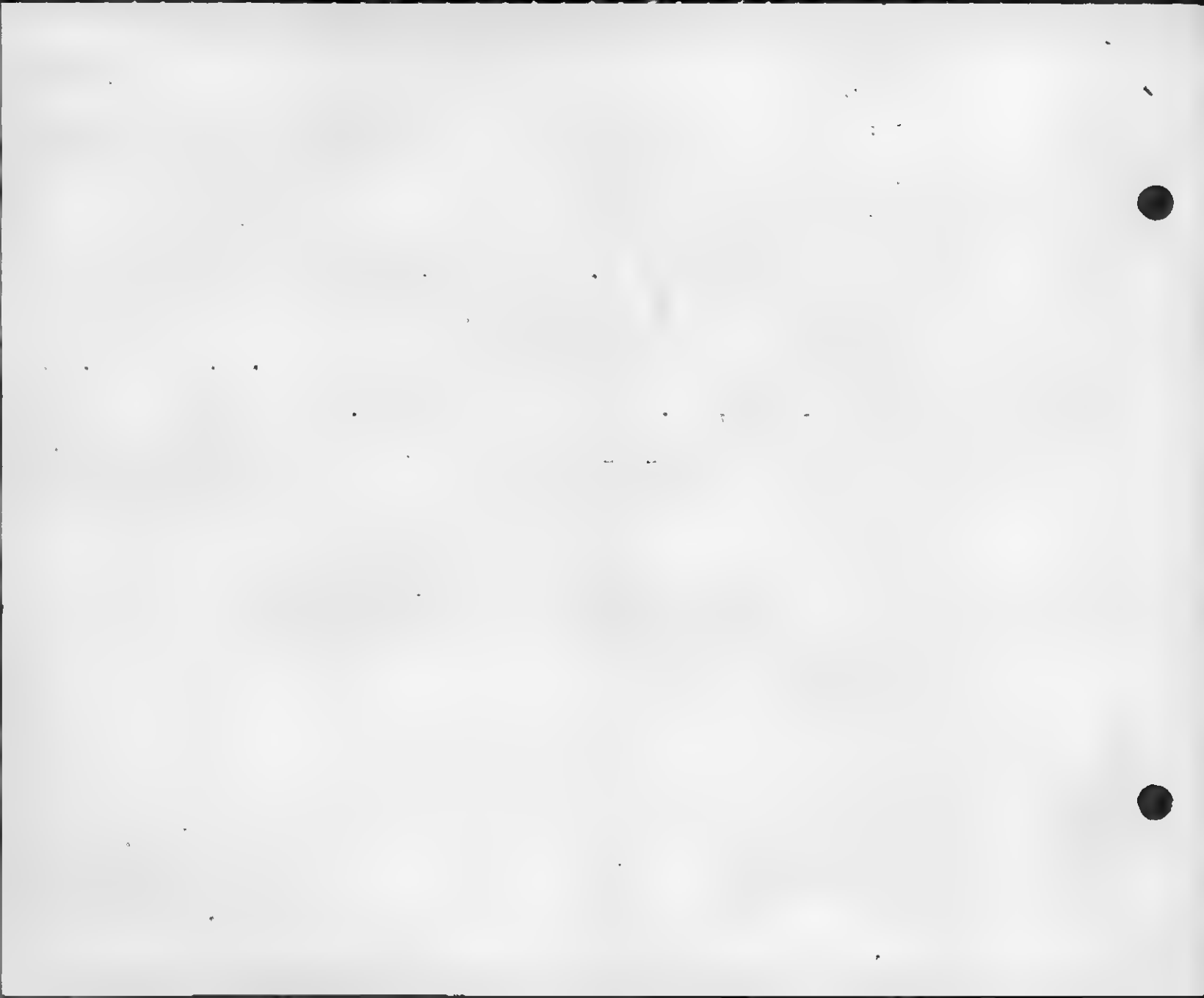
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06956

06939

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 58 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Forest Avenue		d. STREET ADDRESS 11 Forest Ave.	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last PATE, Jr.		4 DATE OF DEATH Month May Day 24 , Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1894
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction Road Building	
11 BIRTHPLACE (County & State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William A. Pate, Sr.		14 MOTHER'S MAIDEN NAME Fannie E. Atkinson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO 579-05-7181	
17 INFORMANT Wife		Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 1/2 hrs. 20-30	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. L. A.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 9/1/1950 to 5/24/1967 that (I) (we) last saw the deceased alive on 5/14/1967 and that death occurred at 7:00 AM , from causes and on the date stated above.			
22a SIGNATURE Stephen N. Jones		22b DATE SIGNED 5/24/67	
22c PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d ADDRESS 809 Viers Mill Rd. Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-27-67	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 29 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26957

06940

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Wisconsin</u> b COUNTY _____			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>				c LENGTH OF STAY IN b <u>2 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e STREET ADDRESS <u>11615 West Harvard Lane</u>			
3 NAME OF DECEASED (Type or print) <u>Henry M. Paulsen</u>				4 DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1967</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Jan. 28, 1886</u>	
9 AGE (in years last birthday) <u>81 yrs</u>		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>CHRISTOPHER PAULSEN</u>				14 MOTHER'S MAIDEN NAME <u>MAGDELINE KIRSCH</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16 SOCIAL SECURITY NO <u>381 01 1430</u>		17 INFORMANT Address <u>ARTHUR MEHIMOLUNAS 5129 15th AVE. HYATTSVILLE, MARYLAND</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiovascular failure</u> (b) <u>renal insufficiency + uremia</u> (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>cardiac enlargement</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-17</u> , 19 <u>67</u> , to <u>5-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-18</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M., from causes and on the date stated above							
22a SIGNATURE <u>Veronica Troost</u> M.D.				22b DATE SIGNED <u>5-19-67</u>		22c PHYSICIAN'S NAME (Type) <u>VERONIKA TROOST</u>	
22d ADDRESS <u>10236 NEW HAVEN SHIRAZ AVE.</u>				22e ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>5-22-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEMETERY</u>		23d CITY OR TOWN, COUNTY, STATE <u>SILVER SPRING, MD. (County) (State)</u>	
24 FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u>				25a REC'D BY REG. STRAR <u>MAY 22 1967</u>		25b REG. STRAR'S SIGNATURE <u>J.C. ... Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06941

FOR STATE HEALTH DEPT

PLACE OF DEATH <i>Montgomery</i>		USUAL RESIDENCE <i>Montgomery</i>	
NAME OF DECEASED <i>Calvin Julian</i>		STREET ADDRESS <i>6416 - 83rd Street</i>	
NAME OF DECEASED <i>ROGER WOOD PAYNE, SR</i>		DATE OF DEATH <i>May 20, 1967</i>	
SEX <i>Male</i>		RACE <i>Cauc</i>	
MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		DATE OF BIRTH <i>JULY 11, 1917</i>	
BIRTHPLACE <i>Washington, D. C.</i>		COUNTRY <i>U. S.</i>	
FATHER'S NAME <i>Herbert Payne</i>		MOTHER'S MAIDEN NAME <i>Edith Wood</i>	
WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes, WW II</i>		16. A SECURITY NO. <i>228-10-8530</i>	
17. INFORMANT <i>Wife</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO (b) <i>Ruptured Congenital Intracranial Aneurysm</i> DUE TO Listing the underlying cause		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME <i>BELDEN R. REAP M.D.</i>		DATE SIGNED <i>May 20, 1967</i>	
Burial		5-25-67	
Cul. pepper Natl Cem.		Culpepper, Virginia	
ROBERT A. PUMPHREY, Bethesda, Maryland		MAY 24 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is caused by the funeral director, the word "pending" in pencil in lines 8, 9, and 10 of the form should be written in the Chief Medical Examiner's Office along with form PM-3. Page 1.

5 may be retained for your files

TO FUNERAL DIRECTOR: This certificate should be retained with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

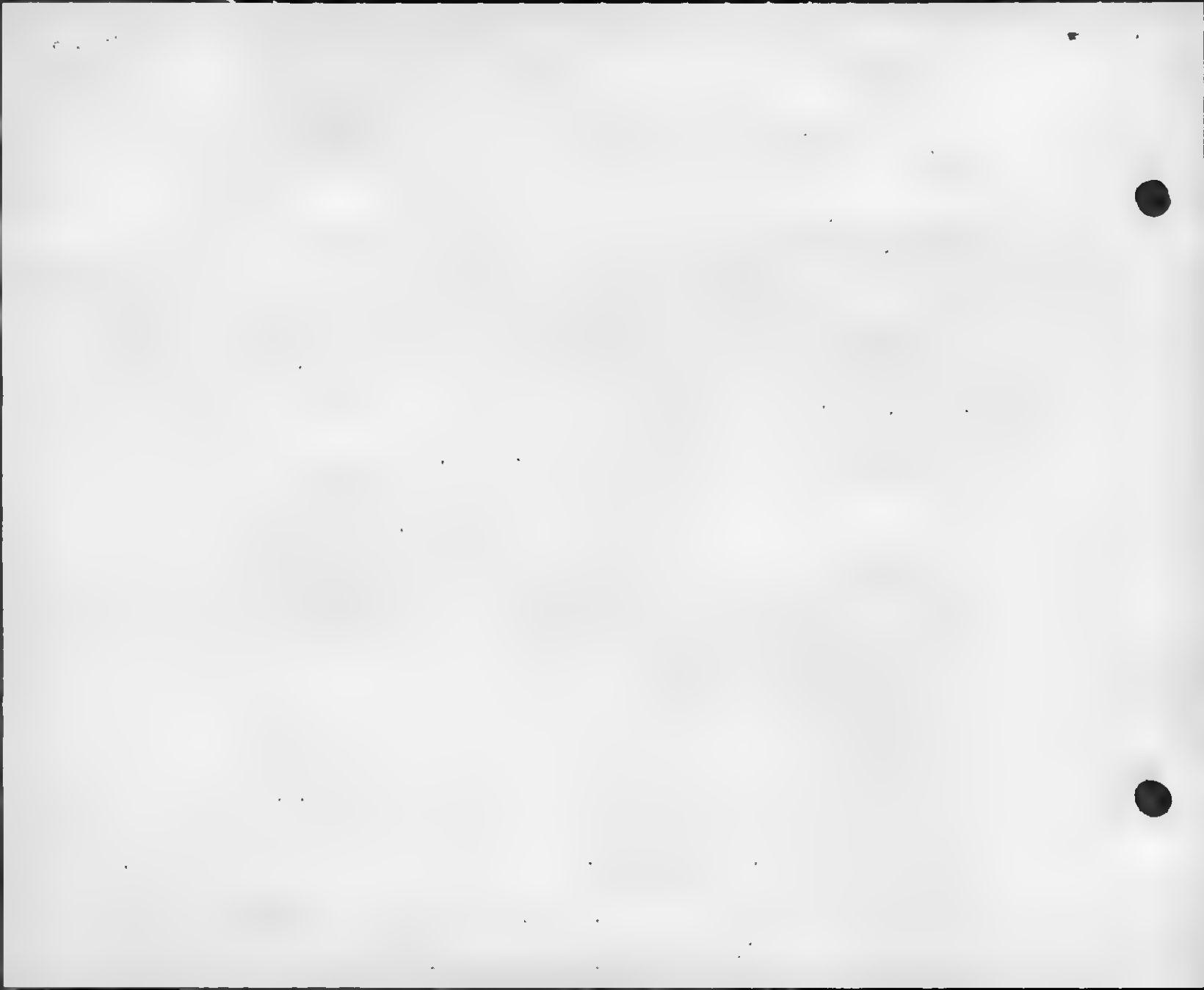
06959

CERTIFICATE OF DEATH

06942

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Virginia</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c LENGTH OF STAY N To <u>1 day</u> d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portsmouth</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>		d STREET ADDRESS <u>9 Helm Street</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Malissa Marie PECHAR</u>		4 DATE OF DEATH Month Day Year <u>May 18 19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 16, 1967</u>
9 AGE (In years lost birthday) yrs <u>2</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Portsmouth, Va.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>John M. Pechar</u>	
14 MOTHER'S MAIDEN NAME <u>Carol Ann Plazio</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>	
16 SOCIAL SECURITY NO <u>N/A</u>		17 INFORMANT Address <u>John M. Pechar, 9 Helm Street, Portsmouth Virginia</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital heart disease, atresia of aortic valve and left ventricle.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (If this hospital) attended the deceased from <u>May 17</u> , 19 <u>67</u> , to <u>May 18</u> , 19 <u>67</u> , that (If (we) last saw the deceased alive on <u>May 18</u> , 19 <u>67</u> , and that death occurred at <u>3:25 P.M.</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Jerry J. Tomasovic</u> M.D.		22b DATE SIGNED <u>May 19, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Jerry J. Tomasovic, M. D.</u>		22d ADDRESS <u>Naval Hospital, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-20-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Pittsburg, Pennsylvania</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a REC'D BY REGISTRAR <u>DATE MAY 24 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 11 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06960

06943

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL c LENGTH OF STAY IN b 10 Days		2 USUAL RESIDENCE (Where deceased lived first ten years of life) a Maryland b COUNTY Lexington Park	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, BETHESDA, MARYLAND		d STREET ADDRESS 32 Salamaua Ct. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Wayne Pendergrass		4 DATE OF DEATH Month Day Year May 31 1967	
5 SEX Male	6 CO. OR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 May 1967
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) Months Days Hours Min 10
11 BIRTHPLACE (County & State or foreign country) Montgomery, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Franklin Pendergrass		14 MOTHER'S MAIDEN NAME Judith Lucile Dunbar	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT James F. Pendergrass		Address Same as Item #2	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7-773 Branchopneumonia DUE TO (b) Hepatic hernia right hemithorax DUE TO (c) Multiple Congenital Anomalies			INTERVAL BETWEEN ONSET AND DEATH with with
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) County (State)
21 I certify that (I) (this hospital) attended the deceased from 21 May 1967 to 31 May 1967 , that (I) (we) last saw the deceased alive on 31 May 1967 , and that death occurred at 8:10 AM , from causes and on the date stated above.			
22a SIGNATURE T. E. Kelly 22c PHYSICIAN'S NAME (Type) T. E. KELLY, M. D.		22b DATE SIGNED 1 June 1967 22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) County (State)
6/2/67	BURIAL	Arlington National Cemetery, Arlington, Virginia	
24 FUNERAL DIRECTOR W.W. Chambers, 400 Chapin St. N.W. Washington, D. C.		25a REC'D BY REGISTRAR JUN 2 1967	25b REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

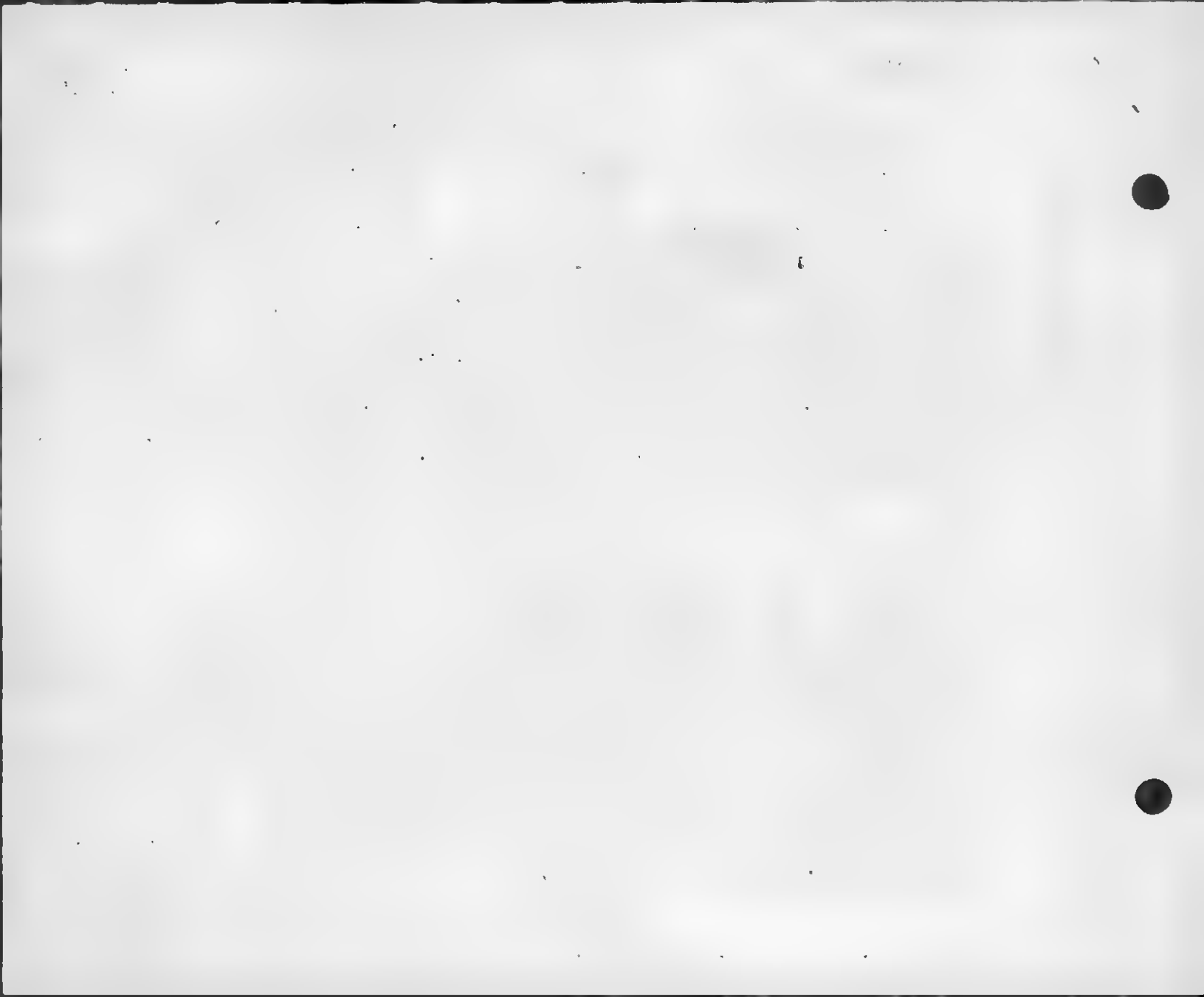
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26961

06944

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN ID 27 hours	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 12919 Ardennes Avenue	
3. NAME OF DECEASED (Type or print) Jo Anne M. Pendleton		4. DATE OF DEATH Month May Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE Caucas	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1953
9. AGE (in years last birthday) 14 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Pendleton		14. MOTHER'S MAIDEN NAME Audrey I. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George E. Pendleton		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured arteriovenous malformation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden L. Hear		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN L. HEAR, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-67	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (Cty, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 29 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



36962

CERTIFICATE OF DEATH

06945

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring</u>		c. LENGTH OF STAY IN IL <u>13 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>H. J. ... Hospital</u>		e. STREET ADDRESS <u>Rockville, Maryland</u>	
3 NAME OF DECEASED (Type or print) <u>Windsor C. Poole</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 11, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William E. Poole</u>		14 MOTHER'S MAIDEN NAME <u>Essie Sheekles</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>579-20-1704</u>	
17 INFORMANT <u>Katherine L. Poole - Item # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction of the heart</u> DUE TO (b) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ED, C.A., HT, & BP</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2/3, 1967</u> to <u>5/6, 1967</u> that (I) (we) last saw the deceased alive on <u>5/5, 1967</u> and that death occurred at <u>Rockville, Md.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen N. Jones</u>		22b. DATE SIGNED <u>5/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		22d. ADDRESS <u>Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cedar Grove, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Healer Funeral Home-1331 Rockville Pike Rockville, Md.</u>		25a. FILED BY REGISTRAR <u>MAY 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06963

CERTIFICATE OF DEATH

06946

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY in lb <i>13 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Silver Spring</i> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>2700 BARBER Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Lottie</i> First Middle Last <i>Propst</i>		4 DATE OF DEATH Month Day Year <i>MAY 26 1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>12/1/02</i>
9 AGE (In years, last birthday) <i>64</i> yrs		10 FUND 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <i>W. Va.</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>DICE PROBST</i>		14 MOTHER'S MAIDEN NAME <i>Mary Alice Simmons</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. (If yes give war or dates of service)	
17 INFORMANT <i>Dorothy Kite - Daughter</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Causations if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <i>13 DAYS 5 YRS</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PULMONARY EMBOLISM DIABETES MELLITUS</i>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day Year Hour am p.m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town, County, State) <i>5/13 1967</i>	
21 I certify that (I) (this hospital) attended the deceased from <i>5/13</i> 19 <i>67</i> to <i>5/26</i> 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>5/26</i> 19 <i>67</i> and that death occurred at <i>5:00 PM</i> , from causes and on the date stated above		22a SIGNATURE <i>David Goldenberg</i> MD 22b DATE SIGNED <i>5/26/67</i>	
22c PHYSICIAN'S NAME (Type) <i>DAVID GOLDENBERG</i>		22d ADDRESS <i>10620 Georgia St. Silver Spring, Md.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>5/28/67</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Monterey</i>		23d LOCATION (City or town, County, State) <i>Monterey, Virginia</i>	
24 FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i> ADDRESS <i>Rockville, Md.</i>		25a REGISTRY REGISTRAR <i>MAY 31 1967</i>	
25b REGISTRAR'S SIGNATURE <i>W. J. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1967 3 24 10 30 AM

CERTIFICATE OF DEATH

06964

06947

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN ID <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beltsville</u>				d. STREET ADDRESS <u>8112 Rayburn Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>B</u> Last <u>Raymond</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. CO. OR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/29/1897</u>	
9. AGE (In years) <u>54 1/2</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Assistant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assistant</u>		11. BIRTHPLACE (County & State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Raymond</u>				14. MOTHER'S MAIDEN NAME <u>Betha</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-03-1313</u>		17. INFORMANT <u>F. A. T. (Phyllis) W. T.</u> Address <u>1111 N. 1st St.</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma to liver and brain</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary carcinoma, right lung</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3</u>
PART 1. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>Advanced coronary arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23</u> , 19 <u>65</u> to <u>5/1</u> , 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Frederick V. Lohm</u>		22b. DATE SIGNED <u>5-1-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Frederick V. Lohm</u>		22d. ADDRESS <u>1512 N. 1st St.</u>	
23a. B. RIAL (CREMATION REMOVAL) (Specify) <u>Removal</u>		23b. DATE THEREOF <u>5-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda, Md. City</u>	
24. FUNERAL DIRECTOR <u>Joseph Saunders Sons</u>				25a. REC'D BY REGISTRAR <u>Charles Jones</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

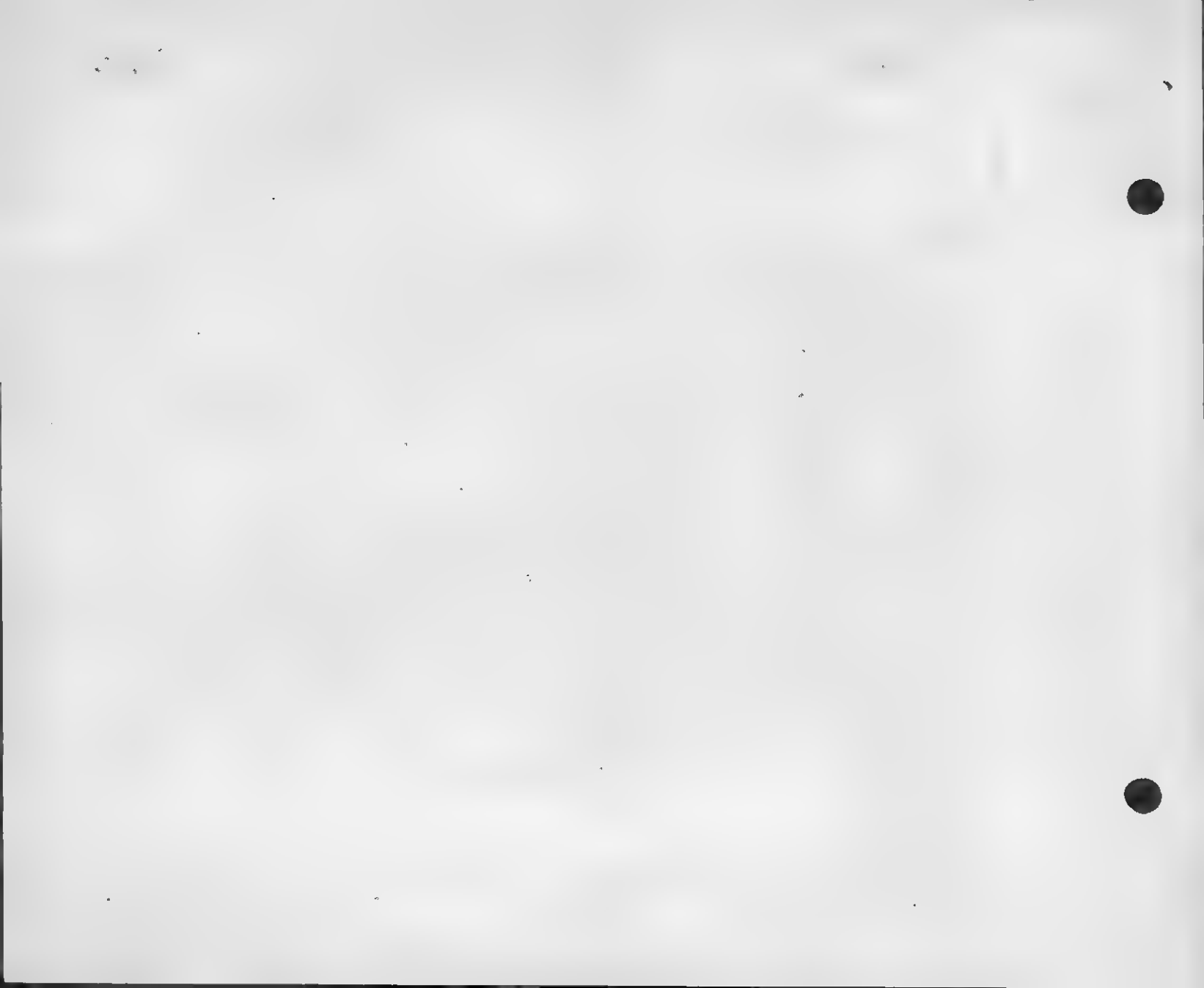
CERTIFICATE OF DEATH

00965

06948

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
c. LENGTH OF STAY .N 1b <u>2 years</u>		d. STREET ADDRESS <u>258 CONGRESSIONAL LANE APT-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>258 CONGRESSIONAL LANE APT-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHESTER CARPENTER ROBERTS</u>	4. DATE OF DEATH <u>MAY 9 1967</u>	5. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1897</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax Appraiser-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>California</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WWI Navy</u>		16. SOCIAL SECURITY NO. <u>561-24-6749</u>	
17. INFORMANT <u>Son</u>		Address <u>291 Rollins Ave. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Hypertension, severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>2 years</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>February</u> , 19 <u>65</u> , to <u>May 9</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>5 May</u> 19 <u>67</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S. Caldwell</u>		22b. DATE SIGNED <u>5/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. CALDWELL</u>		22d. ADDRESS <u>ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 5-11-67</u>		23b. DATE THEREOF <u>5-11-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Suisun-Fairfield Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Fairfield, Calif.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06966

CERTIFICATE OF DEATH

06949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if not full or residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN 1b <u>21 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d STREET ADDRESS <u>17022 King James Way</u>			
3 NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>S.</u> Last <u>Robinson</u>				4 DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/15/107</u>	9 AGE (In years last birthday) <u>59</u> yrs	10 UNDER 1 YEAR Months _____ Days _____		11 IF UNDER 24 HRS Hours _____ Min _____
10a USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Publications Ed.</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Business Editor</u>		11 BIRTHPLACE (County & State, or foreign country) <u>CHIEV CHASE MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>ALFRED L. ROBINSON</u>				14 MOTHER'S MAIDEN NAME <u>ANES EIKER</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOC. SEC. NO. <u>113-07-3933</u>		17 INFORMANT <u>Virginia Beandt</u>		Address <u>2114 Hill Lane</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Arteriosclerosis</u> (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 <u>67</u>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda, Md.</u>		20f (If city or town, county, and state) <u>Bethesda, Md.</u>
21 I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>67</u> , to <u>5/4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/4</u> , 19 <u>67</u> and that death occurred at <u>7:30</u> M, from causes and on the date stated above							
22a SIGNATURE <u>James T. Hooper</u>			22b ADDRESS <u>51517</u>		22c PHYSICIAN'S NAME (Type) <u>JAMES L. HOOPER</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b DATE THEREOF <u>5-8-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md. L.C.</u>				25a REC'D BY REGISTRAR <u>MAY 9 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06967

06950

1. PLACE OF DEATH a COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE New Jersey b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY in 1b 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d STREET ADDRESS R. D. #1, Box 29A	
3. NAME OF DECEASED (Type or print) William Marshall Roche		4. DATE OF DEATH Month May Day 28 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 December 1918
9 AGE (In years lost birthday) 48 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	
11 BIRTHPLACE (County & State, or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO 1942-1945 149-01-5851	
17 INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 7 Days	
DUE TO (b) Possible Septicemia (Clinical)		< hours	
DUE TO (c) Chronic Myelogenous Leukemia		2 Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from 21 May , 19 67 , to 28 May , 19 67 , that (B) (we) last saw the deceased alive on 28 May , 19 67 , and that death occurred at 8:00AM , from causes and on the date stated above			
22a SIGNATURE <i>Paul E. Neiman M.D.</i>		22b DATE SIGNED 28 May 1967	
22c PHYSICIAN'S NAME (Type) Paul E. Neiman, M. D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5/21/67	Mount Holly Cemetery	Mount Holly, Burl., N. J.
24 FUNERAL DIRECTOR JENN B THOMAS		25a REC'D BY REGISTRAR MAY 31 1967	
25b REGISTRAR'S SIGNATURE <i>JENN B THOMAS</i>		25c REGISTRAR'S SIGNATURE <i>JENN B THOMAS</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06968

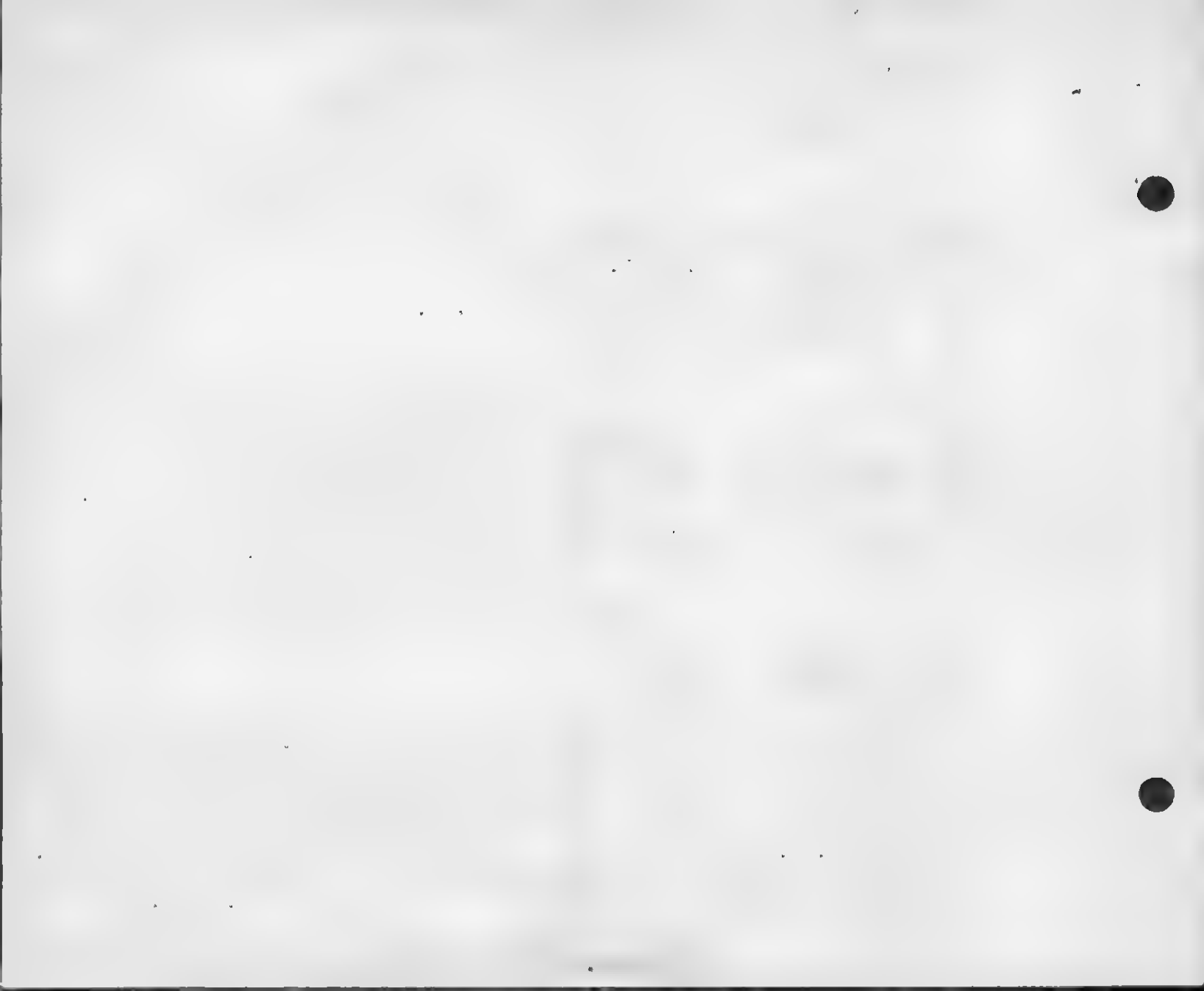
CERTIFICATE OF DEATH

06951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c LENGTH OF STAY IN b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d STREET ADDRESS 832 Rockville Pike e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) OTTO F. K. ROGGE SEX Male 6 COLOR OR RACE White 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH Jan. 26, 1905 9 AGE (In years last birthday) 62 yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 10b KIND OF BUSINESS OR INDUSTRY Naval Hospital 11 BIRTHPLACE (Country & State or foreign country) Germany 12 CITIZEN OF WHAT COUNTRY? USA			4 DATE OF DEATH May 25, 1967 Month May Day 25 Year 1967 13 FATHER'S NAME Unknown 14 MOTHER'S MAIDEN NAME Unknown				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-10-9277		17 INFORMANT Anna B. Rogge - Item # 2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Arteriosclerotic coronary artery disease (c) (symptoms 2 months) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH 2 months		
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 1940 , 19____, to May 25, 1967 , that (I) (we) last saw the deceased alive on May 25, 1967 , and that death occurred at 7:40 AM , from causes and on the date stated above.							
22a SIGNATURE Wm. A. Linthicum		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 5/25/67			
22c PHYSICIAN'S NAME (Type) Wm. A. Linthicum		22d ADDRESS 110 S. Washington St., Rockville, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/27/67		23c NAME OF CEMETERY OR CREMATORY Parklawn			
23d LOCATION (City or Town) (County) (State) Rockville, Montg., Md.		24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.					
25a REC'D BY REG. STRAR MAY 29 1967		25b REGISTRAR'S SIGNATURE J. M. Jones					



**FDR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

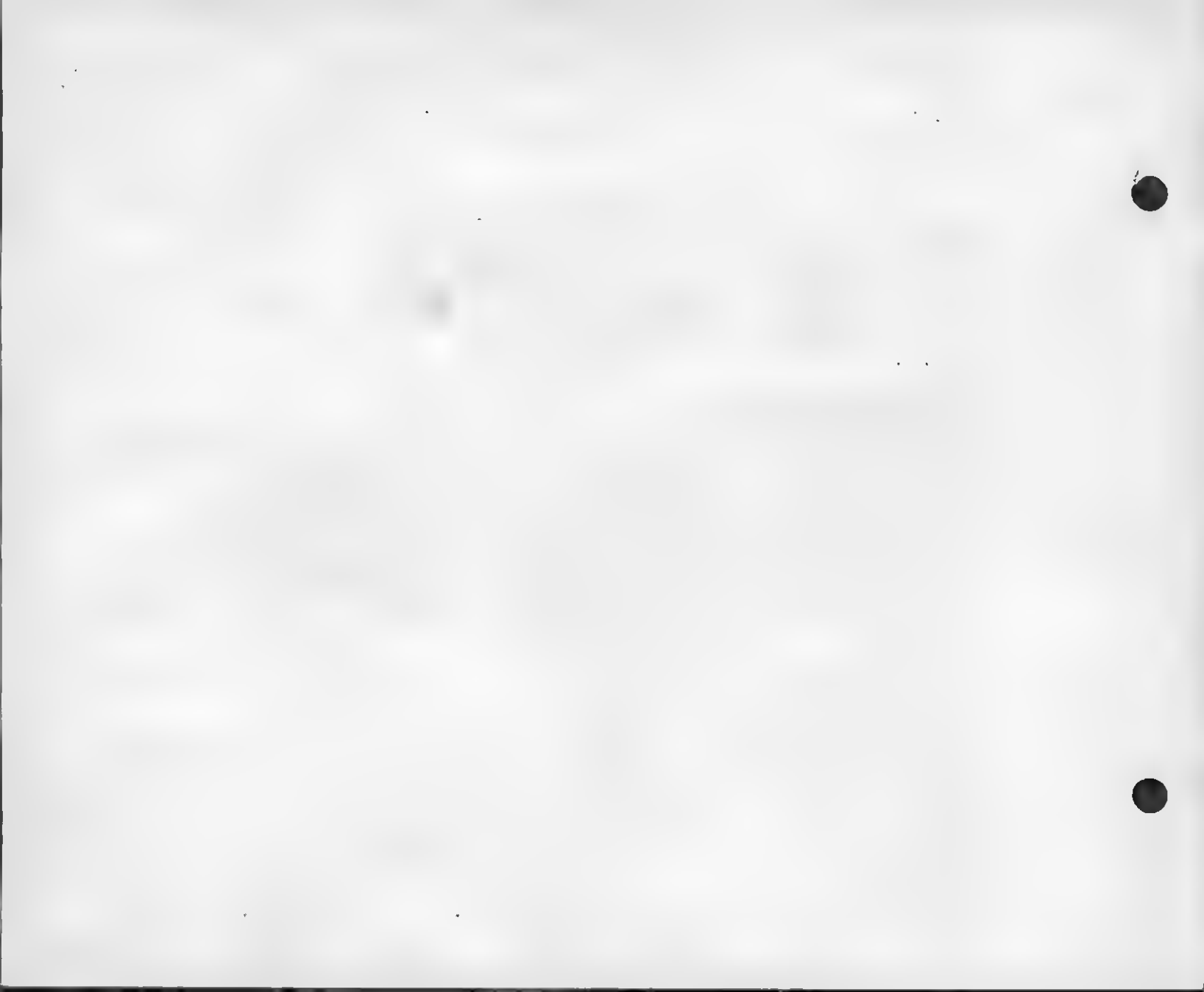
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06952

1 PLACE OF DEATH a. (County) <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. (State) <u>New York</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>New York (City)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>475-W. 186th Street</u>	
3 NAME OF DECEASED (Type or print) <u>IDA</u> First <u>B. ROSENFELD</u> Middle Last		4 DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-20-00</u> 9 AGE in years (last birthday) <u>66</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <u>Benjamin Chadaby</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Goldsmith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		6 SOCIAL SECURITY NO	
17. INFORMANT <u>Rabbi Abraham H. Rosenfeld, St. NY, NY</u>		Address <u>475 W 186th</u>	
18. CAUSE OF DEATH (Enter only one cause per line for 18 and 19) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>due to fall in room</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>due to</u> (c) <u>due to</u>			
PART II. OTHER SIGNIFICANT AND NON-CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Enter them in Part I if given in Part I) <u>None</u>			
20a. EXTERNAL CAUSE: Was PRIMARY OR CONTRIBUTING CAUSE OF DEATH <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury, if any, and if fatal, if item 8 is checked <u>None</u>	
21. MEDICAL HISTORY: Date of Birth <u>12-20-00</u> 19 <u>00</u> 21a. INJURY: <u>None</u> 21b. PALE: <u>None</u> 21c. STREET ADDRESS: <u>None</u>		22. DATE SIGNED <u>May 6, 1967</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> U. date mind <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>May 6, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/9/67</u>	23. NAME OF CEMETERY OR CRIMATORY <u>Riverside Cem.</u>	23d. LOCATION (City, County, State) <u>Lodi, New Jersey</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons St. NW, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>May 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06970

CERTIFICATE OF DEATH

06953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>910 Linwood Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Herman</u> Last <u>Rosenstein</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 November 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Abraham Rosenstein</u>		14. MOTHER'S MAIDEN NAME <u>Lena Korn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alveolar Cell Carcinoma of the Lung</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>4 April</u> , 19 <u>67</u> , to <u>20 May</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>20 May</u> , 19 <u>67</u> , and that death occurred at <u>3:30 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Myron J. Levin</u>		22b. DATE SIGNED <u>20 May 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron J. Levin, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE CEM. WASH.</u>	23d. LOCATION (City or Town) (County) (State) <u>D.C.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME 2nd N.W.</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06971

CERTIFICATE OF DEATH

06954

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 1 Day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		d. STREET ADDRESS 11100 Gainsborough Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Middle Ranier Last RUSTEBERG		4. DATE OF DEATH Month MAY Day 19 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1946
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 19 Days 67 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) ATLANTIC CITY, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl W. RUSTEBERG		14. MOTHER'S MAIDEN NAME Barbara ROGERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-56-264	
17. INFORMANT Carl W. RUSTEBERG		Address POTOMAC, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO FRIEDRICK'S ATAXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETIC ACIDOSIS (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 19 , 19 67 , to May 19 , 19 67 , that (I) (we) last saw the deceased alive on 19 May , 19 67 , and that death occurred at 2:08 P M, from causes and on the date stated above.			
22a. SIGNATURE D.R. FOREMAN		22b. DATE SIGNED 20 MAY 1967	
22c. PHYSICIAN'S NAME (Type) D.R. FOREMAN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF 5-24-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR Jos. Gawler & Sons, 5130 Wisconsin Ave, WDC		25a. REC'D BY REGISTRAR MAY 25 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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